

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 0 4 7 5	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Wayfus</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>4/19/81</i>	
3 SEX <i>Male</i>				2b. HOUR <i>124 P</i>	
4 RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>February 12, 1913</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>68</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <i>Elkton, Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital - Elkton, Md.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co.</i> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Town of Elkton</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Elkton</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Charles Banks (D)</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lula Banks (D)</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>223-22-0455</i>		17. INFORMANT ADDRESS <i>Wayfus E. Banks - 549 Booth St.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>metastatic ca to brain. (Respiratory arrest)</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1850 Poorly differentiated Adenocarcinoma of prostate.</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic ca to lung, bone, Diabetic Mellitus.</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>metastatic ca to lung, bone, Diabetic Mellitus.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <i>4/17/81</i> to <i>4/19</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>4/19</i> , 19 <i>81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.					
22b. SIGNATURE <i>Jui-chih Hsu</i>		DEGREE <i>MD</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jui-chih Hsu</i>		22e. ADDRESS <i>223 West main st - Elkton, Md 21921</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/25/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Elkton Cemetery</i>	
23d. LOCATION CITY OR TOWN <i>Elkton</i>		COUNTY <i>Cecil</i>		STATE <i>MD.</i>	
24. FUNERAL DIRECTOR NAME <i>Ernest M. Congo</i>		ADDRESS <i>201 N. Gray Ave. - Wilm. DE</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 1 1981</i>	
				25b. REGISTRAR'S SIGNATURE <i>Ernest M. Congo</i>	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 10476

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gerald W BERGMANN			2a. DATE OF DEATH MONTH DAY YEAR April 15, 1981			2b. HOUR 6:43P M	
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1933		6 AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) District of Col.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10 CITY OR TOWN OF DEATH Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Veteran Administration			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Contractor	
13a. STATE Maryland			13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Franz Albert Bergmann			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Lillian Allen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean		17 INFORMANT ADDRESS Evelyn B. Maire/sister/ 14615 Claude Lane Silver Spring, Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 3334 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral Bronco Pneumonia (c) Huntington Chorea							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec. 13 , 19 77 , to April 15 , 19 81 , that (I) (we) last saw the deceased alive on April 15 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE ROY CHESNUT, MD <i>Roy W. Chesnut, Jr.</i> DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/15/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROY CHESNUT, MD				22e. ADDRESS VAMC, Perry Point, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-18-81		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P. George Md.	
24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Homes, Silver Spring, MD				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 20 1981			

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MEDICAL CERTIFICATION

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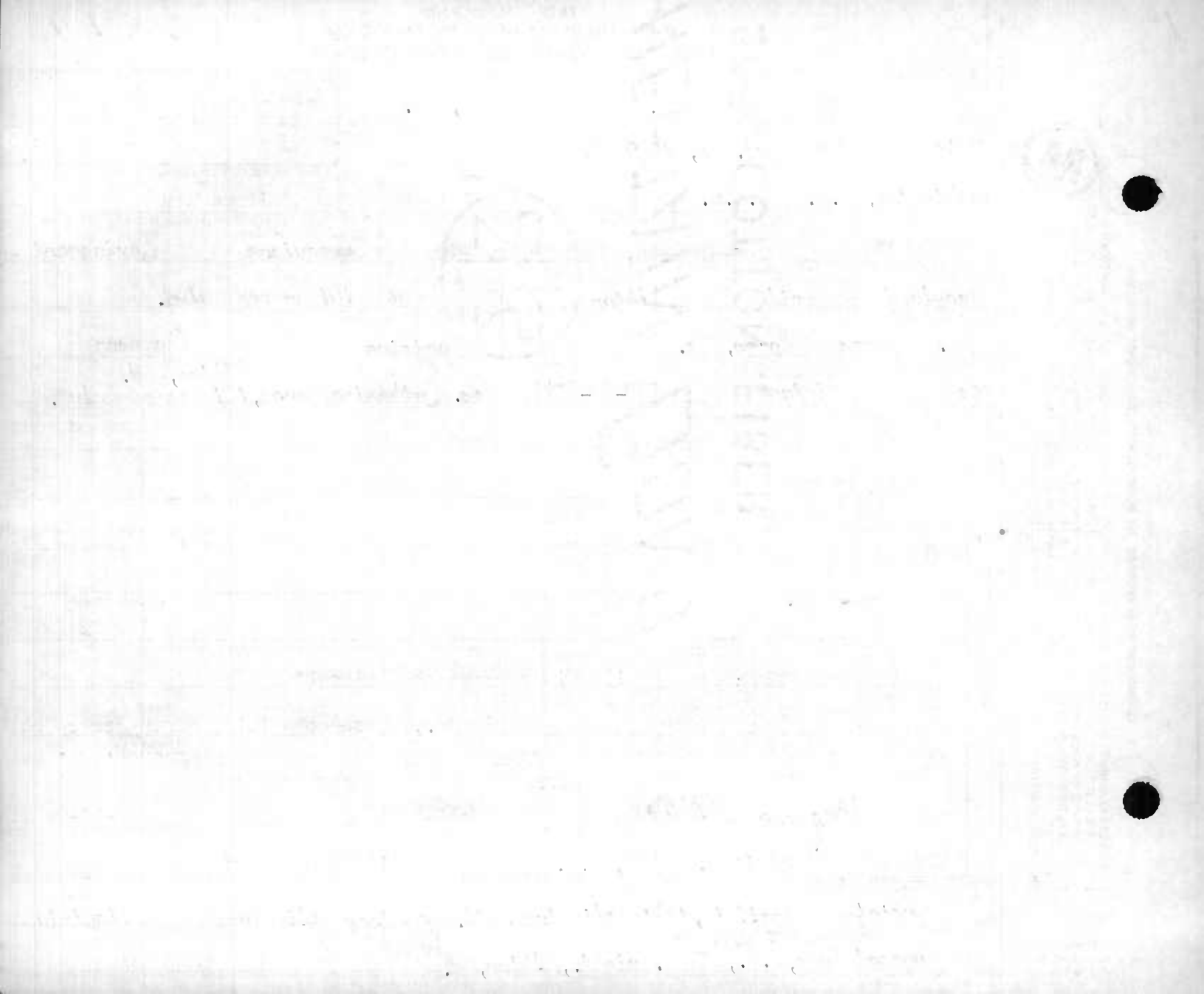
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10477	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John W. Bowen, Sr.										2b. HOUR M 8:25 P. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 13 1981	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County		10. CITY OR TOWN OF DEATH North East		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Robin Road, Chesapeake Isle	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Environment		13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST R. James Bowen, Jr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Thompson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Vietnam 530-20-8544		17. INFORMANT ADDRESS Mrs. Catherine Bowen, 101 Kennedy Blvd., Elkton, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound of Chest</u> 953-4 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 8:15 P.M. 4 13 1981				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot himself			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Robin Rd., Chesapeake Isle, North East, Cecil County, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 4-14-81			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE April 17, 1981				23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery, Arlington			
24. FUNERAL DIRECTOR NAME Edward McKelton				ADDRESS Gee Funeral Home, P.A., 259 E. Main St., Elkton, Md.				25. DATE REC'D BY REGISTRAR APR 21 1981			
				25a. REGISTRAR'S SIGNATURE							



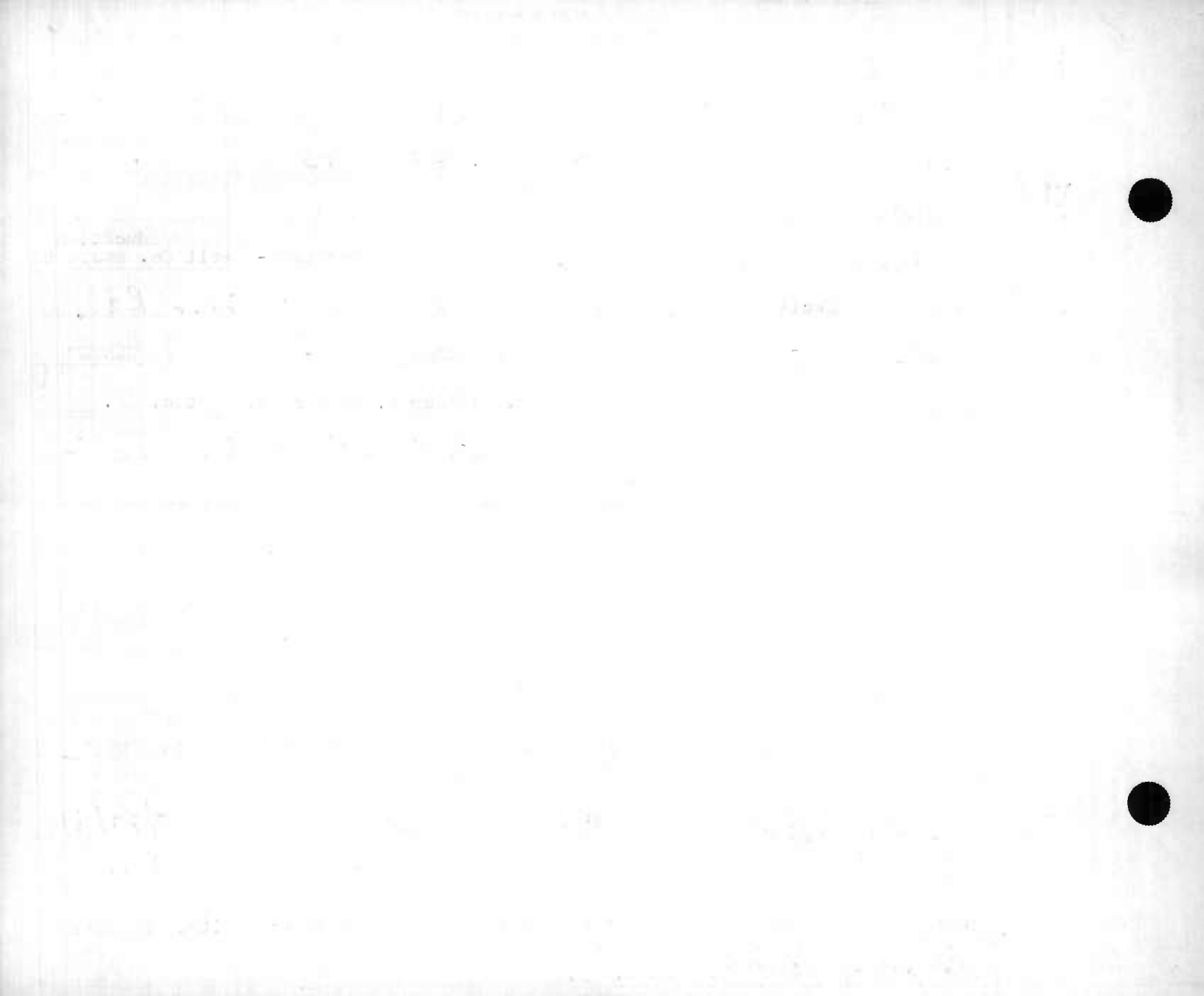
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 0 4 7 8			
1- FOR STATE REGISTRAR <u>Z</u>				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <u>Zolpha C Burkhardt</u>				2a DATE OF DEATH MONTH DAY YEAR <u>April 27 81</u>		2b HOUR <u>8¹⁹ A M</u>	
3 SEX <u>Female</u>		4 RACE <u>Cau</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>NOVEMBER 9, 1907</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>73</u> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>md.</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Cecil</u> MD.	
10 CITY OR TOWN OF DEATH <u>Elkton</u>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Union Hospital</u>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Secretary - Cecil</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Co. Board of</u>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>md</u>		13b COUNTY <u>Cecil</u>		13c CITY OR TOWN <u>Elkton</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME <u>HENRY</u> MIDDLE <u>-</u> LAST <u>CAMERON</u>		15 MOTHER'S MAIDEN NAME <u>ANNA</u> FIRST <u>XXX</u> MIDDLE <u>-</u> LAST <u>FERGUSON</u>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>			
16b SOCIAL SECURITY NO. <u>191-10-8075</u>		17 INFORMANT ADDRESS <u>Mr. William E. Burkhardt, Elkton, Md.</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: <u>3352 Amyotrophic lateral sclerosis Over 3 months</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
IMMEDIATE CAUSE (a) <u>3352</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u> </u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u> </u>							
19a DATE OF OPERATION <u> </u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u> </u> P.M. <u>19</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u> </u>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u> </u>		21f LOCATION STREET <u> </u> CITY OR TOWN <u> </u> COUNTY <u> </u> STATE <u> </u>			
22a I certify that (I) (this hospital) attended the deceased from <u>April 21</u> , 19 <u>81</u> , to <u>April 27</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>April 26</u> , 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>S. Ralph Anderson</u> DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>4/27/81</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. RALPH ANDERSON, MD</u>				22e ADDRESS <u>233 E. Main St., Elkton, Md 21921</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b DATE <u>4/29/81</u>		23c NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		23d LOCATION CITY OR TOWN <u>Chesapeake City, Maryland</u> COUNTY <u> </u> STATE <u> </u>	
24 FUNERAL DIRECTOR <u>HICKS HOME FOR FUNERALS, ELKTON, MD.</u> ADDRESS <u> </u>				25a DATE RECEIVED BY REGISTRAR <u>APR 30 1981</u>		25b REGISTRAR'S SIGNATURE <u> </u>	



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR						8 1 10479					
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Eda A. Cecchini						4 25 81		16-15P			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		March 10, 1905		75		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Delaware		U.S.A.				Cecil County MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Elkton		Union Hospital of Cecil County				Sales		Pharmacy			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland		Cecil		Elkton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		151 West High Street			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME									
Alexander		Nanni		Olivette Disitro							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
No				Mr. Arnold E. Cecchini, Bohemia Church Rd., Middletown, Del.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Act Myocardial Infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension Essential											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from Dec 11, 1980, to Feb 20, 1981, that (I) (we) last saw the deceased alive on Feb 20, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE				DEGREE				22c DATE SIGNED			
Jayantilal K. Patel				M.D.				4/27/81			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
Jayantilal K. Patel, M.D.				123 Singerly Ave., Elkton, Maryland							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION					
Burial		April 28, 1981		All Saints Cem.		Wilmington, New Castle, Del.					
24 FUNERAL DIRECTOR NAME		25a DATE RECEIVED BY REGISTRAR 25b REGISTRAR'S SIGNATURE									
Gee Funeral Home, Inc., 249 E. Main St., Elkton, Md.		APR 30 1981									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 0 4 8 0

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lela L. Cleaver</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4/23/81</i>		2b. HOUR AM PM <i>110 A</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 6, 1903</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YEARS MONTHS DAYS HOURS AM PM		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.		
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <i>Delaware New Castle Christiana</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>32 S. Old Baltimore Pike</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles H. Leasure</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katie Crumbine</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>221-12-8849</i>		17. INFORMANT ADDRESS <i>Del. 19713 Audrey C. Laws 15 Kitty Lane, Newark,</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CONGESTIVE HEART FAILURE</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>RECENT MYOCARDIAL INFARCTION</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>POSSIBLE BRONCHITIS</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>4/19</i> , 19 <i>81</i> , to <i>4/22</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>4/22/81</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death.								
22b. SIGNATURE <i>Ehsanur Rahman</i>				DEGREE <i>M.D.</i>			22c. DATE SIGNED <i>4/23/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EHSANUR RAHMAN</i>				22e. ADDRESS <i>314 E. MAIN ST, SUITE 102 NEWARK, DE 19711</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/27/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Presbyterian Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Christiana, New Castle, Del</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>Robert T. New</i> <i>Newark, Del.</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 27 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 8 1 1 0 4 3 1			
FOR 1 - STATE REGISTRAR				CERTIFICATE OF DEATH			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EUGENE F. C. COLLIER				2a. DATE OF DEATH MONTH DAY YEAR April 3 81			
3. SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 7, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Perry Point, Cecil Co. MD.	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center, Perry Point, Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. M.C.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE None 13b. COUNTY None 13c. CITY OR TOWN Washington, DC				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME Walter Collier LAST				15 MOTHER'S MAIDEN NAME Mary Shea FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI & WWII 577 44 1076		17 INFORMANT ADDRESS Wife-Madelyn W. Collier - Same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: b) Arteriosclerotic Heart Disease c) Bilateral Bronchopneumonia, Cerebral Arteriosclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6-7 , 19 79 , to 4-3 , 19 81 , that (I) (we) last saw the deceased alive on 4-3- 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Klaus H. Huebner				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/3/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KLAUS H. HUEBNER, M.D.				22e. ADDRESS VAMC, PERRY POINT, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-7-81		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.	
24. FUNERAL DIRECTOR NAME DeVol Funeral Home, Washington, D.C. ADDRESS				25a. DATE REC'D. BY REGISTRAR APR 8 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

Devol National Home, Washington, D.C.

Washington National Co., Washington, Va.

U.S. Army, 1917

U.S. Army, 1917

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U.S. Army, 1917

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10482	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Deborah Louise Davis						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 30 19 81		2b. HOUR M 5:35A			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 28, 1962 18 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS.		7c. DATE PRONOUNCED DEAD 4 30 19 81		7d. HOUR 5:35A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Elkton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician		12b. KIND OF BUSINESS OR INDUSTRY Betty's Cutaway	
13a. STATE Maryland				13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 501 Carpenters Point Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Donald Ray Davis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emmileen Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218-74-9583		17. INFORMANT Emmileen Davis		ADDRESS 501 Carpenters Point Rd. Perryville, Md. 21903			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thermal injury 8151 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:30xx 4/30 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger in auto/fixed object collision					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Principio Rd, Port Deposit, Cecil Co. MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE H. R. Guard						TITLE (SPECIFY) Assistant		M.D. MEDICAL EXAMINER		DATE SIGNED 4/30/81	
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.						ADDRESS 111 Penn Street, Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 4, 1981		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford MD	
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 5 1981		25b. REGISTRAR'S SIGNATURE			



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701 Woodland Court
Newville, Pa. 17241

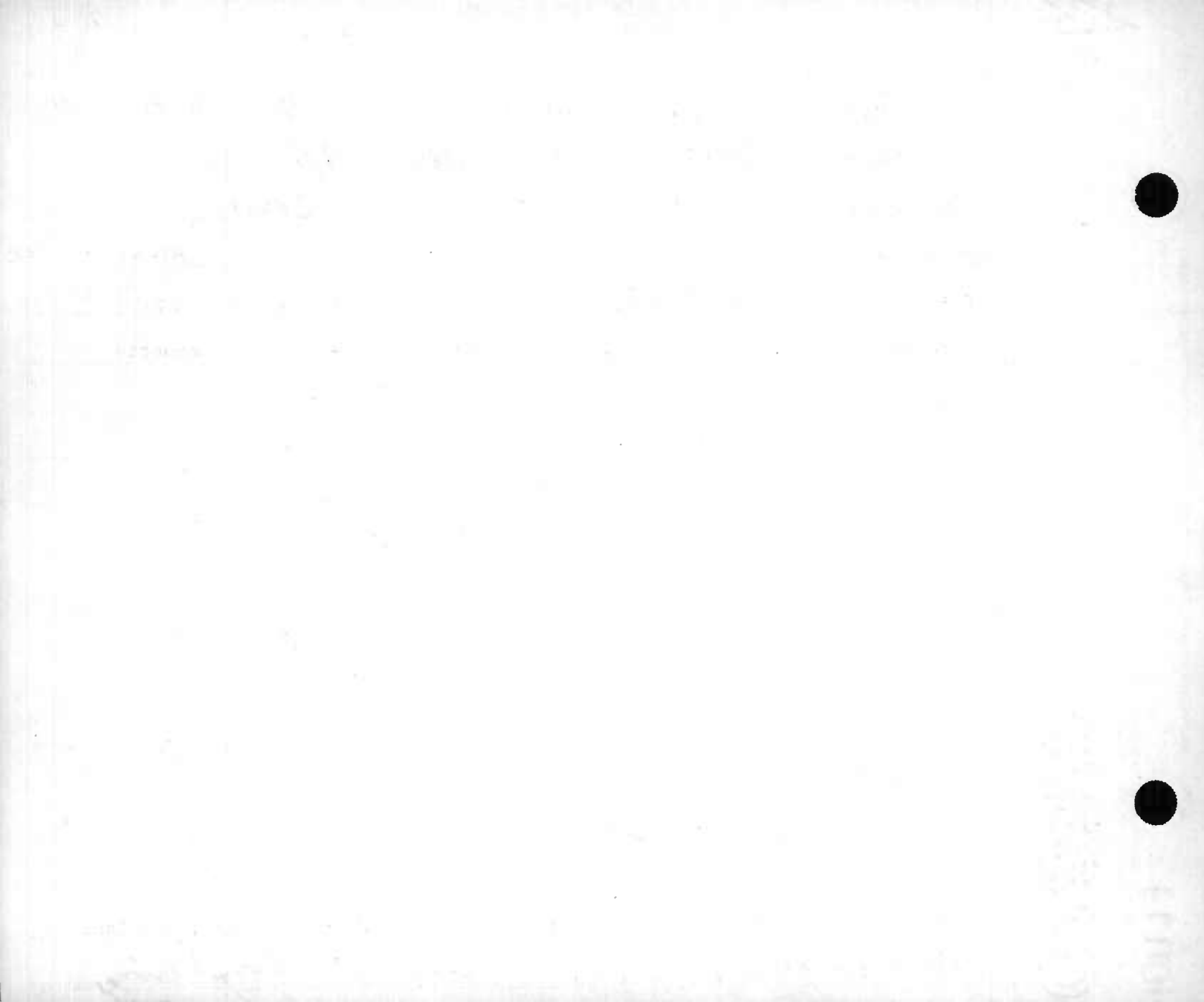
1000 6 342

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

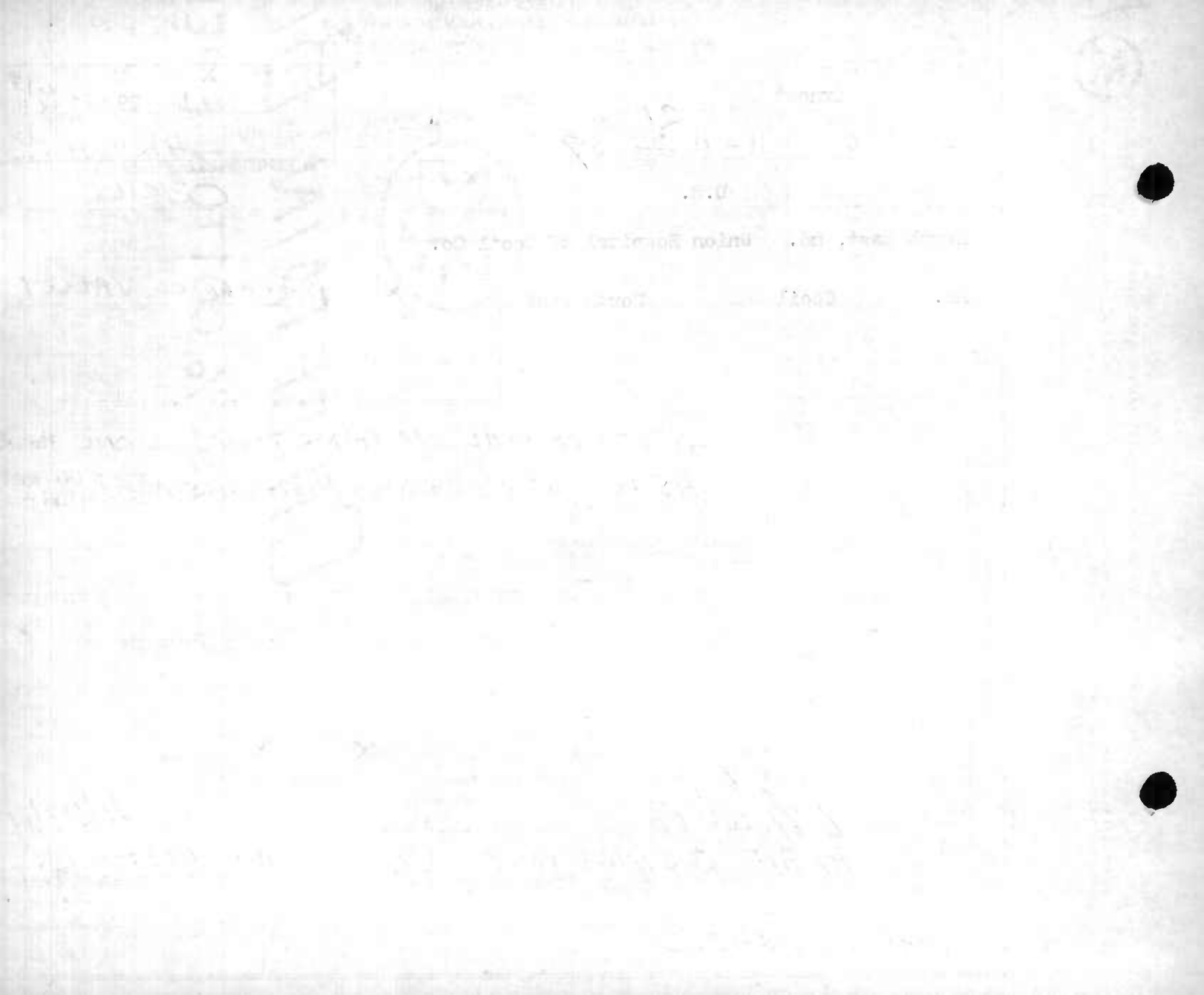
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 0 4 8 3		
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) John T. DAVIS					2a. DATE OF DEATH MONTH 4 DAY 4 YEAR 81		2b. HOUR 8:30 P.M.					
3. SEX Male		4. RACE CAUC		5. DATE OF BIRTH MONTH 1 DAY 11 YEAR 1886		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.						
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LAURELWOOD NRSNG CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRAVELED		12b. KIND OF BUSINESS OR INDUSTRY ATLAS POWDER				
13a. STATE PA					13b. CITY OR TOWN Chester		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 401 LOCUST ST.			
14. FATHER'S NAME FIRST Harry MIDDLE H. LAST Davis					15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE - LAST Jaquette							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 221-03-0052A		17. INFORMANT ADDRESS BILL MILLER PA. 215-932-2648					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest 4960 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) COPD										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a):												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from JAN 26TH 19 81 to APRIL 4TH 19 81 that (I) (we) lost saw the deceased alive on APRIL 2ND 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Joseph G. Lanzi				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH G. LANZI				22e. ADDRESS 721 BRIDGE ST. ELKTON MD 2192								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/7/81		23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Havre de Grace, Maryland				
24. FUNERAL DIRECTOR NAME Joseph E. Hickey ADDRESS HICKS HOME FOR FUNERALS, ELKTON, MD.				25a. DATE REC'D. BY REGISTRAR APR 10 1981		25b. REGISTRAR'S SIGNATURE Raymond H. Boring						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10484		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) Ernest Day						2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX M			4. RACE C		5. DATE OF BIRTH 11-11-22		6. AGE (IN YEARS) 57 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 4/29/1981	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.			
10. CITY OR TOWN OF DEATH North East, md.			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil Co.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Auto			
13a. STATE Md.			13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS MECHANICS VALLEY			
14. FATHER'S NAME FIRST MIDDLE LAST Henry Day			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patty Thornsberry			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes WW II			16b. SOCIAL SECURITY NO. 236-18-3632			
17. INFORMANT ADDRESS Lawrence Day 2456 Old Elk Neck Rd. Elkton, Md. 21921			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause listed. (b) ARTERIO-SCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE HOUR			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE [Signature]			TITLE (SPECIFY) M.D. DEPUTY			DATE SIGNED 4/29/81			25b. REGISTRAR'S SIGNATURE			
EXAMINER'S NAME (TYPE OR PRINT) ANANT B. SINGH, MD			ADDRESS UNION HOSPITAL, ELKTON, MD			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-2-81			
24. FUNERAL DIRECTOR NAME [Signature]			23c. NAME OF CEMETERY OR CREMATORY Day Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Paynesville Mc Dowell Va.			25a. DATE REC'D. BY REGISTRAR MAY 4 1981			
Crouch Funeral Home North East, Md.												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Deranek, Edward J.		2a. DATE OF DEATH MONTH DAY YEAR April 11, 1981	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1900	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 80	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN EACH FACILITY, GIVE STREET ADDRESS) V.A. Medical Center		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil	
13a. STATE Virginia		13b. CITY OR TOWN Alexandria		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		12b. KIND OF BUSINESS OR INDUSTRY --	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 137 03 1661		17. INFORMANT ADDRESS VAMC, Perry Point, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure second degree to 4289 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile dementia DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME; STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from 2-5- 19 81 , to 4-11- 19 81 , that (X) (we) lost saw the deceased alive on 4-11- 19 81 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rahul Sangal		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAHUL SANGAL, M.D.		22e. ADDRESS VAMC, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 15, 1981		23c. NAME OF CEMETERY OR CREMATORY Hollywood Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Union, Union, New Jersey		25a. DATE REC'D. BY REGISTRAR APR 15 1981		25b. REGISTRAR'S SIGNATURE Forney	
24. FUNERAL HOME (NAME AND ADDRESS) McCracken Funeral Home, Union, N.J.					

8:10AM

April 11, 1981

Deanne

Barbara L.

Barbara L.

White	Nov. 19, 1900	80
137		100

Virginia	Alexandra	James	Unknown
100	100	100	100

137 03 1981 VANC, Perry Point, Maryland

Cardiac failure neurog. heart co.
Genetic hemophilia

4-11-81 1-5-81 4-11-81

VANC, Perry Point, Md. VANC, N.D.

April 11, 1981
VANC, Perry Point, Md. VANC, N.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the hospital or retained by the hospital or attending physician.

DHMH-16 25M
(VRA 15, 4) 1/79



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		3. DATE OF DEATH		4. HOUR	
Margaret J. Dilks		4/8/81		4/8/81		4:30 A.M.	
5. SEX		6. RACE		7. DATE OF BIRTH		8. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		May 27, 1921		59 YRS.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. MARITAL STATUS		12. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Cecil MD	
13. CITY OR TOWN OF DEATH		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		16. KIND OF BUSINESS OR INDUSTRY	
Elkton		Union Hospital		Clerk		Florist	
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		18. INSIDE CITY LIMITS?		19. STREET ADDRESS			
17a. STATE		17b. CITY OR TOWN		17c. STREET ADDRESS			
Maryland		Elkton		247 E. Main Street			
20. FATHER'S NAME		21. MOTHER'S MAIDEN NAME		22. ADDRESS			
George Hollett		Mary A. Sweeney		Mr. Walter A. Dilks, Sr. Elkton, Md.			
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		24. SOCIAL SECURITY NO.		25. INFORMANT			
No				Mr. Walter A. Dilks, Sr. Elkton, Md.			
26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>C.O.P.D. Emphysema and bronchitis</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4920 DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic severe with congestive heart failure</u>						Over 1 yr.	
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ()							
27. DATE OF OPERATION		28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY?		30. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
31. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		32. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		33. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
34. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		35. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		36. LOCATION STREET CITY OR TOWN COUNTY STATE			
37. I certify that (I) (the hospital) attended the deceased from Jan. 26, 1979, to April 8, 1981, that (I) (we) saw the deceased alive on April 7, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
38. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						39. DATE SIGNED	
S. Ralph Andrews, M.D.						4/8/81	
40. PHYSICIAN'S NAME (TYPE OR PRINT)				41. ADDRESS			
S. Ralph Andrews, M.D.				233 E. Main St., Elkton, Md. 21921			
42. BURIAL, CREMATION, REMOVAL (SPECIFY)		43. DATE		44. NAME OF CEMETERY OR CREMATORY		45. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		4/10/81		Cratin and Ferris Crematory, West Chester, Pa.			
46. FUNERAL DIRECTOR NAME				47. DATE REC'D. BY REGISTRAR 48. REGISTRAR'S SIGNATURE			
HICKS HOME for FUNERALS, ELKTON, MD.				APR 13 1981			



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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

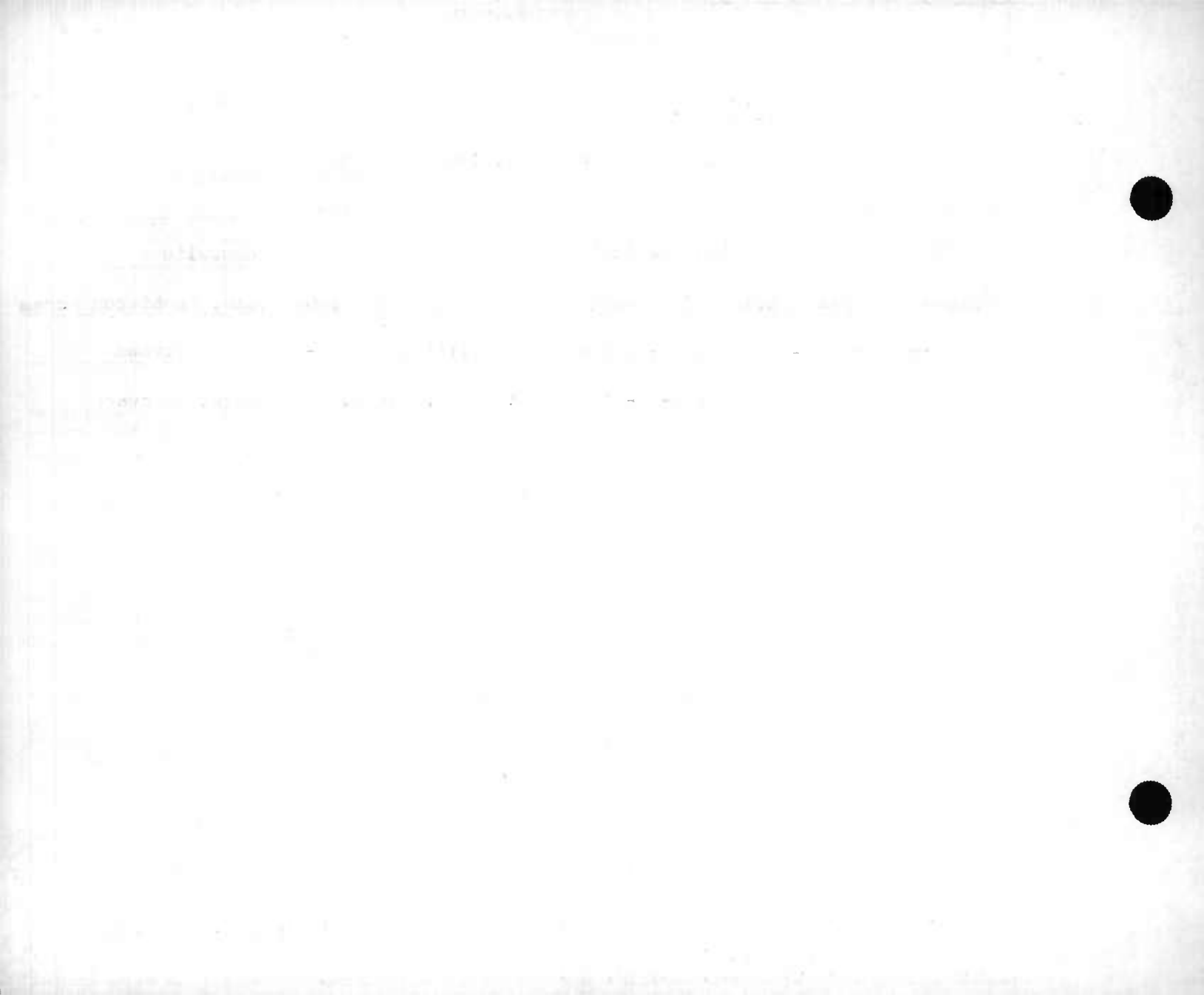
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8110487

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST MARION D. Dixon		2a. DATE OF DEATH MONTH DAY YEAR 4/22/81		2b. HOUR 1025 A	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 11, 1943		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware		13b. COUNTY New Castle		13c. CITY OR TOWN New Castle		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin - DiFerdinando		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian - Stroud		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-42-3189	
17. INFORMANT ADDRESS Marvin E. Dixon, New Castle, Delaware		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEPATIC FAILURE 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COLON CARCINOMA (c) HEPATIC FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 4/1/81 , 19 81 , to 4/22 , 19 81 , that (1) (we) lost saw the deceased alive on 4/22 , 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Yogish A. Patel		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/23/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yogish A Patel		22e. ADDRESS NEWARK Del					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/25/81		23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Delaware	
24. FUNERAL DIRECTOR NAME Donald B. Hicks		ADDRESS HICKS HOME for FUNERALS, ELKTON, MD.		25a. DATE REC'D. BY REGISTRAR APR 30 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

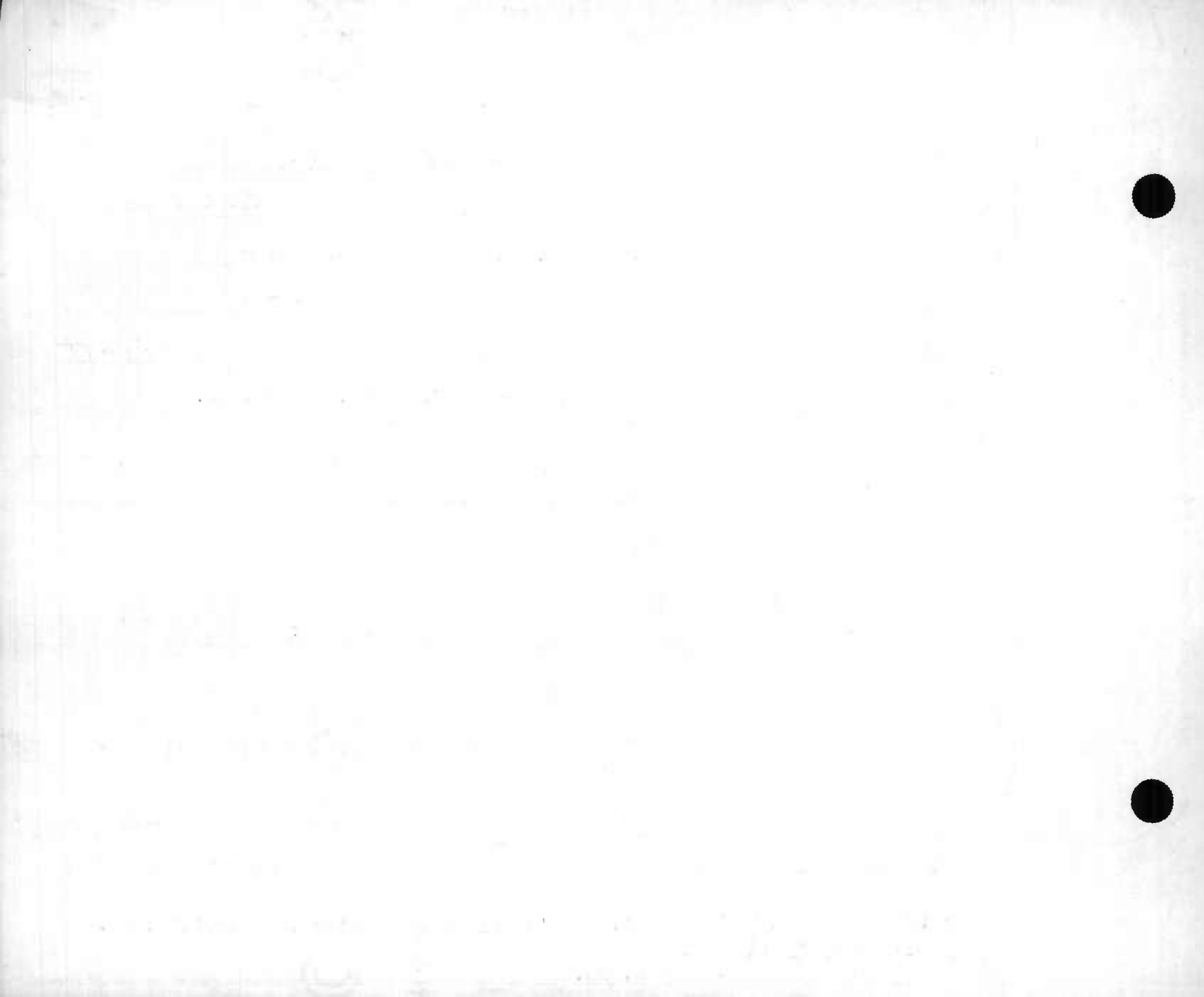
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 81 10488	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Charles E. Fatty				2a. DATE OF DEATH MONTH DAY YEAR 4 19 81		2b. HOUR 3:30 AM			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10 14 94		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD.					
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Laurelwood Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Pa.		13b. COUNTY Chester		13c. CITY OR TOWN Oxford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD 3			
14. FATHER'S NAME FIRST MIDDLE LAST John Fatty		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Pratt									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 184-30-1638A		17. INFORMANT ADDRESS Harold E. Fatty, Oxford, Pa.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409 Dehydration DUE TO, OR AS A CONSEQUENCE OF (b) Depression DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from MARCH 13th 19 81 to APRIL 15th 19 81, that (I) (we) last saw the deceased alive on APRIL 12th 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Joseph G. Lanzani				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/20/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH G. LANZI				22e. ADDRESS 721 BRIDGE ST, ELKTON MD 21921							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/22/81		23c. NAME OF CEMETERY OR CREMATORY St. John's Methodist Cemetery, Lewisville, Pa.		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Donald S. Hicks ADDRESS HICKS HOME for FUNERALS, ELKTON, MD.				25a. DATE REC'D. BY REGISTRAR APR 23 1981		25b. REGISTRAR'S SIGNATURE [Signature]					

BP

DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					REG. NO. 8110489				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
JOSEPH E. GEELHAAR Sr.					April 21, 1981				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
Male		White		Mar. 20, 1899		82		10:25am	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Cecil County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
Perry Point		VA Medical Center							
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12c. KIND OF BUSINESS OR INDUSTRY		
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS		
Maryland					Balto.		9629 Tenth Avenue		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Ernest J. Geelhaar					Mary Sutton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
yes					WW1		212-05-6274 family records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardiac arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) Atrial fibrillation									
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from February 24, 1979, to April 21, 1981, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
							4-21-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
GLADYS OCEJO, M.D.					VAMC, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
burial			4/24/81		Dulaney Valley		Baltimore County, Md.		
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Evans Funeral Home, Parkville, Md.					8800 Harford Rd.		APR 29 1981		

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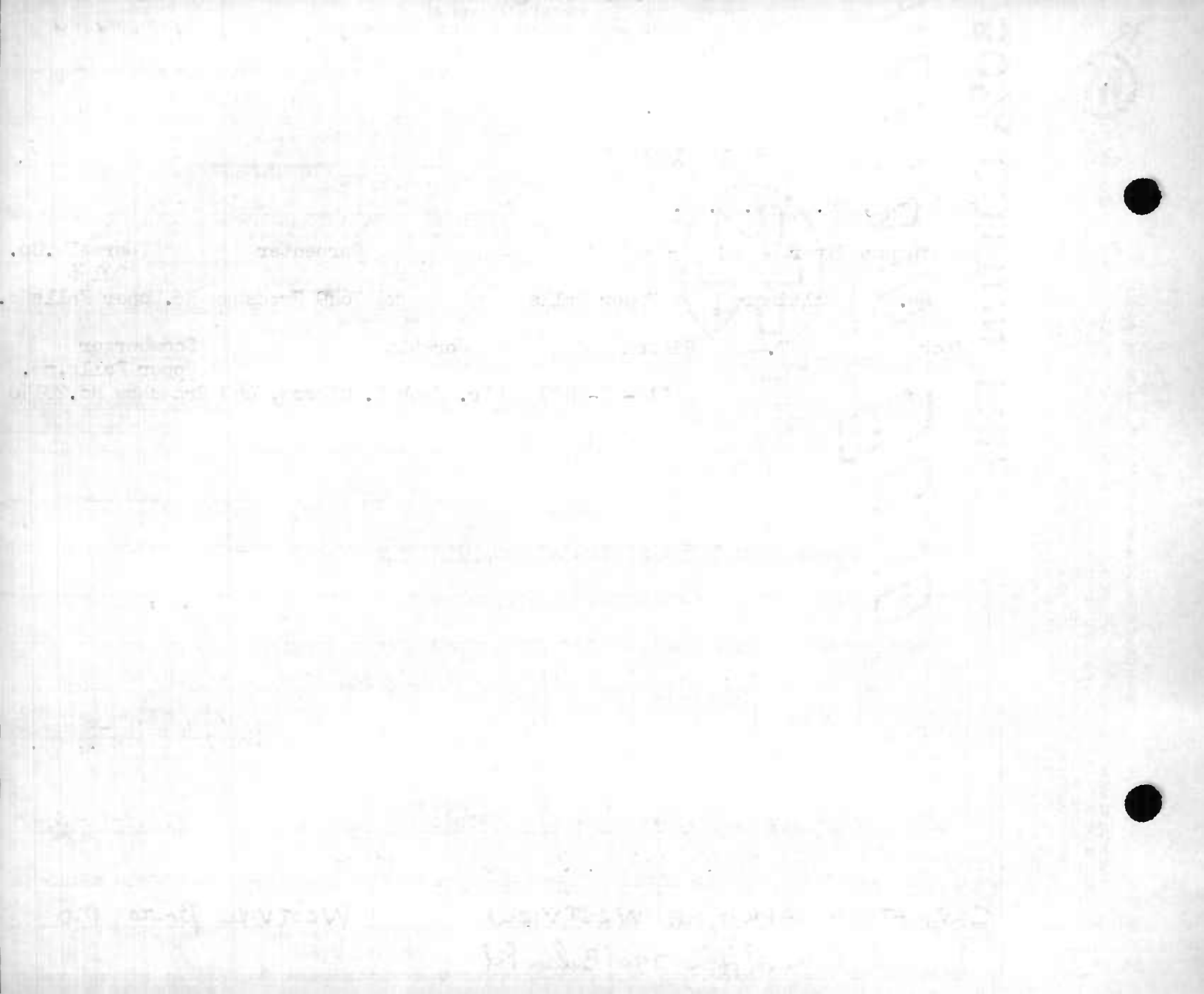
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10490	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Kelly D. Gibson							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 22 1981		2b. HOUR M 4:30 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 10 1960		6. AGE (IN YEARS) LAST BIRTHDAY 20 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.		
10. CITY OR TOWN OF DEATH Susquehanna River			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1/2 mile north of Bald Friar's Landing-Susquehanna River			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter			12b. KIND OF BUSINESS OR INDUSTRY Thermal W. Co.		
13a. STATE Md.			13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Upper Falls		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7640 Bradshaw Rd. Upper Falls Md. 20156		
14. FATHER'S NAME FIRST MIDDLE LAST Jack T. Gibson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joretta Snowberger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 218-72-9820		17. INFORMANT ADDRESS Dr. Jack T. Gibson, 7640 Bradshaw Rd. 20156 Upper Falls, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 8300 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:00 AM 3 22 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject in canoe that capsized					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) river		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1/2 mile north of Bald Friar's Landing-Susquehanna River, Cecil Co., Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 4-14-81			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE APR 15, 1981		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW			23d. LOCATION CITY OR TOWN COUNTY STATE WESTVIEW BALTO MD			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home						ADDRESS 7401 Belair Rd		25a. DATE REC'D. BY REGISTRAR APR 20 1981		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rhoda Eulah Givens			2a. DATE OF DEATH MONTH DAY YEAR April 6, 1981			2b. HOUR M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Jan. 22, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Worton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.F.D.#	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Walley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 218-16-7676		17. INFORMANT ADDRESS R.F.D.# Mrs. Florence Tinch Worton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial infarction. 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 1975, 19, to 6 April 1981, that (I) (we) last saw the deceased alive on 6 Apr 1981, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Wallace G. Obenshain M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8 Apr 81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace G. Obenshain M.D.				22e. ADDRESS Cecilton, Maryland 21613					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE April 11, 81		23c. NAME OF CEMETERY OR CREMATORY Union United		23d. LOCATION CITY OR TOWN COUNTY STATE Worton Kent Md.			
24. FUNERAL DIRECTOR NAME Kenneth W. Wooten				ADDRESS Chestertown, Md.		25a. DATE OF DEATH APR 9 1981		25b. REGISTRATION SIGNATURE [Signature]	

MEDICAL CERTIFICATION

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APR 2 1981

Dr. T. M. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Frederick John Goldworthy			2a. DATE OF DEATH MONTH DAY YEAR 4-23-81		2b. HOUR 9:55P M	
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 13, 1889	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Elkton, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital-Elkton, MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Cecil 13c. CITY OR TOWN Elkton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 50 Bonney Shore Road	
14. FATHER'S NAME FIRST MIDDLE LAST William Goldworthy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Harvey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 202-10-5015		17. INFORMANT ADDRESS Ruth G. Miles, 324 S. Concord Rd., West Chester, Pa.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Uremia 4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Lobar Pneumonia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 27 days 14 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from March 29 , 19 81 , to April 23 , 19 81 , that (I) (we) lost saw the deceased alive on April 23 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Victor M. Magalong, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-24-81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor M. Magalong, M.D.				22e. ADDRESS 325 E. Main St., Newark, DE 19711		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 27, 1981		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Dela. Pa.
24. FUNERAL DIRECTOR NAME Geoffrey McKeown ADDRESS Geoffrey McKeown, P.A., 259 E. Main St., Elkton, Md.				25a. DATE REC'D. BY REGISTRAR APR 30 1981		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8110493	
1. FOR STATE REGISTRAR			REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Howard William Graves					April 6, 1981	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)
Male		White		4 14 1907		73
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, Md.		U. S. A.				Cecil Co. MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Perry Point, Md.		VA Medical Center, Perry Point, Md.		Store keeper		Baltimore City
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?
Md.		Harford		Fallston		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS		
Bernard Graves		Nellie Sadler		603 Wilgis Rd. Fallston, Md. 21047		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
yes		WW11		Mrs. Elsie Graves, Fallston, Md. 21047		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from January 18, 1973, to April 6, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE		22c. DATE SIGNED		
Prem Lal		XXXXXX		4-6-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
Prem Lal		VA Medical Center, Perry Point, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		4-10-1981		Belair Mem. Gardens		Belair Harford Md.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Kingsville, Md.		APR 13 1981				
Lassahn Funeral Home, 11750 Bel Air Rd., 21087						

BP



November 1981

13 1981

...

VA Medical Center, Fort Polk, LA

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...

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Arteriosclerotic Cardio Vascular Disease

...

January 1981

4-8-81

VA Medical Center, Fort Polk, LA

Page 101

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMM-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Wilding Arthur Haley					2a. DATE OF DEATH MONTH DAY YEAR Apr 11 1981			2b. HOUR 8:50 AM		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Mar 11 1922		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7c. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.				
10 CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware					13b. CITY OR TOWN Newcastle		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS RD #2	
14. FATHER'S NAME FIRST MIDDLE LAST unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST xxxxxx Alma C. Petterson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 222-10-8926		17 INFORMANT ADDRESS Daughter-Shirley O'Neal					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lungs 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Primary not known - could be metastatic DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pericardial effusion Possible alcoholic cardiomyopathy										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Mar 10, 1981, to Apr 11, 1981, that (I) (we) lost saw the deceased alive on Apr 11, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE Wallace Obenshain M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Apr 12, 1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Obenshain, M.D.					22e. ADDRESS Cecilton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-15-81		23c. NAME OF CEMETERY OR CREMATORY Townsend Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Townsend, N.C. Dela.			
24 FUNERAL DIRECTOR NAME William J. Hawick ADDRESS Newark, Dela					25a. DATE REC'D BY REGISTRAR APR 15 1981		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

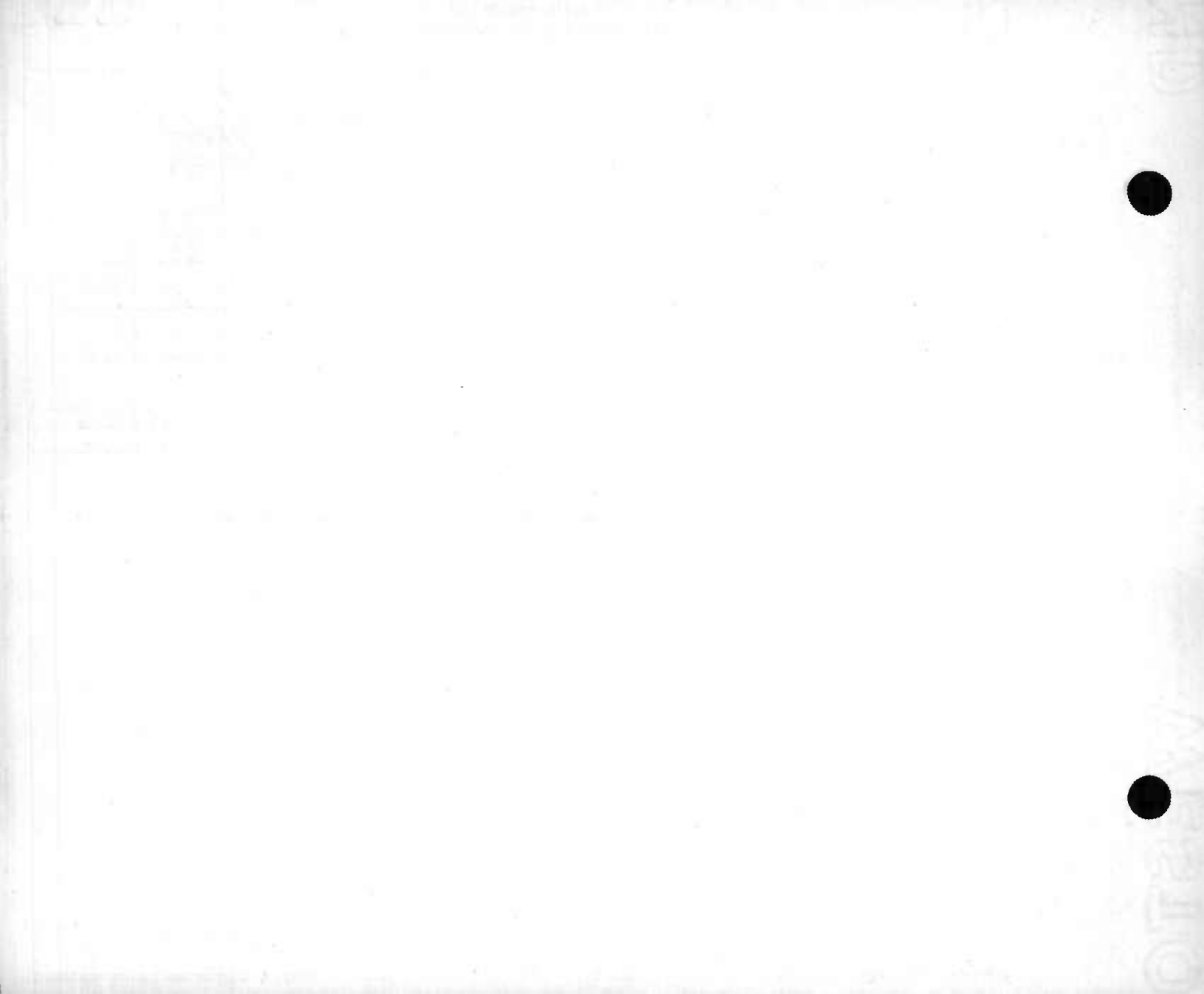
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARENCE B. Hamilton			2a. DATE OF DEATH MONTH DAY YEAR 4/17/81			2b. HOUR MIN. 1130 A			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 20, 1928		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 52		7. UNDER 1 YEAR MONTHS DAYS 52	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Civil Service	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 101 shady Beach Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Hamilton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Irwin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Charloette L Hamilton North East, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4/140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 4 years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (1) (this hospital) attended the deceased from 3/18 , 19 81 , to 4/17 , 19 81 , that (1) (we) lost saw the deceased alive on 4/17 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
27b. SIGNATURE Edgar E. Folk III						DEGREE M.D.		27c. DATE SIGNED 4/20/81	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar E Folk III MD						27e. ADDRESS Elkton, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-21-81		23c. NAME OF CEMETERY OR CREMATORY North East Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.		
24. FUNERAL DIRECTOR Paul R. Gough						ADDRESS North East, Md.		25a. DATE RECEIVED BY REGISTRAR APR 21 1981	
						25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Charles E. Hart					2a. DATE OF DEATH MONTH DAY YEAR April 23, 1981		2b. HOUR 9:05PM		
3 SEX Male		4 RACE White Black		5. DATE OF BIRTH MONTH DAY YEAR Nov. 30, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) No Info		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR NAVY) WOW		17. INFORMANT ADDRESS VAMC, Perry Point, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest, renal failure 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease with aortic insufficiency and stenosis DUE TO, OR AS A CONSEQUENCE OF (c) Cerebro vascular insufficiency									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Seizure disorder and osteomyelitis right leg									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-6- 19 81 , to 4-23- 19 81 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4-23- 19 81 , and that in xx (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did XXXXXX view the body after death.									
22b. SIGNATURE Joseph J. Kim M.D.					DEGREE M.D.			22c. DATE SIGNED 4-23-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH J. KIM, M.D.					22e. ADDRESS VAMC, Perry Point, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-28-81		23c. NAME OF CEMETERY OR CREMATORY Culpeper National		23d. LOCATION CITY OR TOWN COUNTY STATE Culpeper Va.			
24. FUNERAL DIRECTOR NAME Paul R. Bouch ADDRESS Crouch Funeral Home, North East, Md.					25a. DATE REC'D. BY REGISTRAR APR 30 1981		25b. REGISTRAR'S SIGNATURE Henry McCreedy		

BP

Charles E. Hart April 23, 1981

120 24 7550 VANC, Perry Point, Maryland

Cystic respiratory arrest, renal failure

Arteriovenous heart disease with aortic insufficiency and stenosis
Cerebral vascular insufficiency

Seizure disorder and osteomyelitis right leg

VANC MEDS 642-2411

Card 287-6166

VANC, Perry Point, Maryland

108 PM 1. 11. 11. 11.

108 PM 1. 11. 11. 11.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 1 1 0 4 9 7	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		3. REG. NO.	
PHELPS		April 13, 1981		10:05p M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	White	Aug. 22, 1926	54 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
New York	U.S.A.		Cecil MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Perry Point	VA Medical Center Perry Point, Md.		Boat Builder		---
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
D.C.	---	Washington	YES <input type="checkbox"/> NO <input type="checkbox"/>	---	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
Henry	Eleanor		(Unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
Yes	1944-45	V.A.M.C. Records, Perry Point, Maryland.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 2050 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myelomonocytic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 10</u> , 19 <u>81</u> , to <u>Apr 13</u> , 19 <u>81</u> , that <u>X</u> (we) last saw the deceased alive on <u>Apr 13</u> , 19 <u>81</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>XX</u> (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
Prem Lal	M.D.				4-13-81
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
PREM LAL, M.D.	VAMC Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY	STATE
Burial	April 21, 1981	Culpeper National C em	Culpeper		Virginia
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lee A. Patterson & Son, Perryville, Maryland.		APR 21 1981			

BP _____

Lee H. Patterson & Son, 1 University Avenue.

March 21, 1961 (Superintendent of Fisheries)

FROM LEE H. PATTERSON, JR.

4-13-61
X
APR 13 1961
NOT 10 61
APR 13 61

Acute lymphocytic leukemia
Respiratory failure

Year 1964-65 052-10-8472 V.A.A. Records, New York, New York.
Tumor Throat Cancer (Unknown)

D.C. --- Washington

New York White
X
(Recd)

New York

WHITE
DATE
APR 13 1961
10:00

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
STEPHEN S JACKSON					April 18, 1981					5:00A M
SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE	CAUCASIAN	JAN 10, 1899		82 YRS.		MONTHS		DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MASSACHUSETTS	U.S.A.			CECTI MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
PERRY POINT	VA Medical Center Perry Point, Md.			LAWYER						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
MARYLAND	MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3311 S. LEISURE WORLD BLVD.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST SAMUEL STEPHEN JACKSON				FIRST MIDDLE LAST CATHERINE FITZGERALD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
YES		WW I		565-38-9894		RUTH L. JACKSON		SAME AS 13 WIFE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) PNEUMONITIS										
4148										
DUE TO, OR AS A CONSEQUENCE OF										
(b) GRAM-NEGATIVE SEPTICEMIA										
DUE TO, OR AS A CONSEQUENCE OF										
(c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
CHRONIC BRAIN SYNDROME, SENILE DEMENTIA, DECUBITI, OLD MYOCARDIAL INFARCTION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
		P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 11, 19 73, to Apr 18, 19 81, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Apr 18, 19 81, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) did not view the body after death.										
22b. SIGNATURE		DEGREE				22c. DATE SIGNED				
Glendon Rayson M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				4-18-81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS						
GLENDRON RAYSON, M.D.				VAMC Perry Point, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE
BURIAL		4/21/81		GATE OF HEAVEN		SILVER SPRING		MONT		MD.
24. FUNERAL HOME OR PLACE				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Collins Funeral Home, 500 Univ. Blvd, Silver Spring, Md						APR 20 1981				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1801 81-11-04

VA Medical Center Perry Point, Md.

4929-88-202

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ANALYTICAL CHEMISTRY

43-797

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1108

44

6279A

XX.

17-511-4

WAVE PERIOD: 10.0

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First MARY	Middle B.	Last JOHNSON	2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> April 27 19 81		2b. HOUR P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH August 26, 1894	6. AGE (In years last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month April Day 27 Year 1981	2d. HOUR 6:30AM
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 228 Whitehall Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Christopher		Middle -		Last Weedman		15. MOTHER'S MAIDEN NAME First Rebecca	
Middle -		Last Croper		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16b. SOCIAL SECURITY NO. 216-46-0153		17. INFORMANT Mr. Paul J. Johnson, Elkton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Colon DUE TO, OR AS A CONSEQUENCE OF (c) -							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks 6 years?
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Cancer of Colon				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Peter Staropolski		EXAMINER'S NAME (Type) PETER STAROPOLSKI MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/27/81	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/30/81		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Chesapeake City, Md.	
24. FUNERAL DIRECTOR Hicks Home for Funerals		ADDRESS Elkton, MD.		25a. REC'D BY REGISTRAR DATE MAY 4 1981		25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours

after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

REPORT OF THE
COMMISSIONER OF THE GENERAL LAND OFFICE
ON THE
LANDS BELONGING TO THE UNITED STATES
IN THE
STATE OF CALIFORNIA
FOR THE
YEAR 1890

THE
LANDS BELONGING TO THE UNITED STATES
IN THE
STATE OF CALIFORNIA
FOR THE
YEAR 1890

Item 8 854 4/29/81 83

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT) CHARLES J. KEHOE			2a. DATE OF DEATH MONTH DAY YEAR April 11, 1981		2b. HOUR 9:24A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 20, 1905^R	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10. CITY OR TOWN OF DEATH Perry Point	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A. Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Laborer	12b. KIND OF BUSINESS OR INDUSTRY --	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Cecil	13c. CITY OR TOWN Perry Point	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel J. Kehoe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Grow			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 177 05 2051	17. INFORMATION ADDRESS VAMC, Perry Point, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4289 IMMEDIATE CAUSE (a) Cardiac failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-27- 19 79 to 4-11- 19 81 , that <input checked="" type="checkbox"/> (we) lost saw the deceased <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. 4-11-19-81 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE Rahul Sangal		DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAHUL SANGAL, M.D.		22e. ADDRESS VAMC, Perry Point, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 17, 1981	23c. NAME OF CEMETERY OR CREMATORY Culpeper National Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Culpeper Virginia		
24. FUNERAL DIRECTOR NAME ADDRESS Lee A. Patterson & Son, Perryville, Maryland		25. REGISTERED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE RR 21 1981			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Lee H. Patterson & Son, "Carleton."

April 11, 1901, Labor National Com. Indiana,

Indiana

RAMSEY WARDEN, M.D.

W.M.C. Perry Point, Maryland

4-11-01

11-27-79

4-11-01

W.M.C.

W.M.C. Perry Point

W.M.C.

11-27-79

XX

Carleton Institute

Will

177 02 2051 W.M.C. Perry Point, Maryland

Garland

Kelroe

Landie

W.M.C.

W.M.C. Perry Point

W.M.C. Perry Point

Laborer

Perry Point

U.S.N.

(Rec'd)

note

White

Nov. 20, 1905

77

CHARLES J. KESLER

April 11, 1901

U.S.N.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 10501	
1- STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) <i>Colleen McKeever King</i>			2a DATE OF DEATH MONTH DAY YEAR <i>4-7-81</i>		2b HOUR <i>5:45 P.M.</i>
3 SEX <i>FEMALE</i>	4 RACE <i>WHITE</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>March 21 1924</i>	6 AGE (IN YEARS LAST BIRTHDAY) <i>57</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <i>YRS.</i>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PA.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <i>CECIL</i>		
10 CITY OR TOWN OF DEATH <i>ELKTON</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>UNION HOSP.</i>	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>	12b KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		
13a STATE <i>MD.</i>		13b COUNTY <i>CECIL</i>	13c CITY OR TOWN <i>NOTTINGHAM</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS <i>NOTTINGHAM R.D. # 1 BOX 230C PA.</i>
14 FATHER'S NAME FIRST MIDDLE LAST <i>WALTER</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>WINNIE SCHAFER</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>211-12-3287</i>	17 INFORMANT ADDRESS <i>OSCAR KING SAME AS ABOVE</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HEPATIC FAILURE</i> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <i>BREAST CANCER</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Yogish A. Patel</i>		DEGREE <i>MD</i>		22c DATE SIGNED <i>4/9/81</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>YOGISH PATEL</i>		22e ADDRESS <i>NEWARK DEL. OR UNION HOSP. ELKTON MD.</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIED</i>	23b DATE <i>4-10-1981</i>	23c NAME OF CEMETERY OR CREMATORY <i>ROSEBANK CEM.</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>CALVERT CECIL MD.</i>	
24 FUNERAL DIRECTOR <i>Rising Sun</i>		25a DATE REC'D. BY REGISTRAR <i>APR 14 1981</i>		25b REGISTRAR'S SIGNATURE <i>Patricia McBrady</i>	



FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last Ruth Estelle Lauck			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 4 9 1981			2b. HOUR 1:30 PM			
3. SEX F	4. RACE C	5. DATE OF BIRTH 4-27-13	6. AGE (In years last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 4 9 1981			2d. HOUR 1:30 PM
7a. BIRTHPLACE (State or foreign country) N.J.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil			
10. CITY OR TOWN OF DEATH Earleville, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Cecil		13c. CITY OR TOWN Earleville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER P. O. Box 172, Button Beach		
14. FATHER'S NAME First Middle Last George Scott			15. MOTHER'S MAIDEN NAME First Middle Last Alice Donovan			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.			
16b. SOCIAL SECURITY NO. 152-07-8187			17. INFORMANT ADDRESS Alfred Wm. Lauck, P.O. Box 172, Earleville Md. 21919						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029 HYPERTENSIVE ARTERIOSCLEROTIC DUE TO, OR AS A CONSEQUENCE OF CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEVERAL YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS									
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 -		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) -					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) -		21f. LOCATION Street or R.F.D. No. City or Town County State -					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Anant B. Singh, M. D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 4/9/81			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April, 11, 81	23c. NAME OF CEMETERY OR CREMATORY St. Rose of Lima Cem.			23d. LOCATION (City or Town) (County) (State) Chesapeake City, Cecil Md.			
24. FUNERAL DIRECTOR Edward Fellows & Son, Millington, Md.			ADDRESS 21651			25a. REC'D BY REGISTRAR APR 15 1981		25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours

after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR Charles LEMBECK					2a. DATE OF DEATH MONTH DAY YEAR April 25, 1981			2b. HOUR 2:50p M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 7 1914		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.					
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center Perry Point, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland					13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8804 Lowell Place		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Lembeck					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anita Buismann						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. 11/46 - 11/65 212-38-6686		17. INFORMANT Winifred M. Lembeck			ADDRESS 8804 Lowell Place Bethesda, Md. 20034	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 3320 DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) Parkinson's Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 23 , 19 81 , to Apr. 25 , 19 81 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Apr. 25 , 19 81 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William Rennie					DEGREE M.D.			22c. DATE SIGNED 4/25/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM A. RENIE, M.D.					22e. ADDRESS VAMC Perry Point, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE April 28, 1981		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery Company		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.					
24. FUNERAL DIRECTOR NAME Leo A. Patterson & Son, Inc.					25. DATE REC'D BY REGISTRAR MAY 1 1981						
25b. REGISTRAR'S SIGNATURE [Signature]											

1-207

April 22, 1961

Letter

White

Author

Male

White

7/19/61

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR					7. DATE OF DEATH MONTH DAY YEAR							2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR			
Elwood J. Loller					4/6/81 April 6, 1981					17:00a.m.			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		6/10/09			71 years		YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA					Cecil County MD.						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Elkton		Union Hosp. of Cecil County								Auto Mechanic		Hand Chev.	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland				Cecil		Elkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		655 Augustine Herman Hwy			
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
James D. Loller				Mary Emma Craig									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS							
no				218-05-7556		Myrtle Loller (wife)			-same-				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Ca to Brain</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca of Lung</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD Diabetes: early onset. cerebral</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital) attended the deceased from <u>10/10</u> 19 <u>78</u> to <u>4/6</u> 19 <u>81</u> that (I) (we) last saw the deceased alive on <u>4/5</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <u>Jui Chih Hsu</u> DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				4/6/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
Jui Chih Hsu M.D.				223 West Main St, Elkton Md. 21921									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				4/8/81		Johntown Cemetery		Earleville Cecil Maryland					
24 FUNERAL DIRECTOR NAME ADDRESS						25a. DATE OF DEATH BY REGISTRATION		25b. PHYSICIAN'S SIGNATURE					
Edw. Fellows and Son Millington, MD 21651						APR 15 1981							

APR 15 1981

Handwritten signature

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10505	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER T. MALONE										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 29 19 81	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR March 29, 1909		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 72		7. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 29 19 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.				10. CITY OR TOWN OF DEATH Elkton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stauffer Chemical Corp.				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland				13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 660 Blue Ball Road	
14. FATHER'S NAME FIRST MIDDLE LAST Noah Thomas Malone						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie - Dugger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW2		17. INFORMANT Mrs. Elizabeth Malone, Elkton, Md.		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9550 IMMEDIATE CAUSE (a) Gunshot wound of chest (handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 4-29- 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 660 Blue Ball Rd., Elkton Cecil Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. Smith, M.D.				TITLE (SPECIFY) M.D. Deputy Chief Medical Examiner				DATE SIGNED 4-29-81			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/2/81		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Union Cecil, Md.	
24. FUNERAL DIRECTOR HICKS HOME FOR FUNERALS, ELKTON, MD.						25a. DATE REC'D. BY REGISTRAR MAY 6 1981		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

20% POLYOMER-FIBRE

6. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840.

1999-2000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | 2a. DATE OF DEATH | | | MONTH | | | DAY | | | YEAR | | | 2b. HOUR | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Joseph | | | G | | | Martin | | | April 8, 1981 | | | 11:25PM | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | |
| Male | | | White | | | Dec. 27, 1895 | | | 85 | | | MONTHS | | | DAYS | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Maryland | | | U.S.A. | | | | | | Cecil County | | | | | | MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Perry Point | | | VA Medical Center, Perry Point, Md | | | Navy Ret. | | | | | | Gov't. | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | 21128 | | |
| Maryland | | | Baltimore | | | Perry Hall | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 9917 Pepper Hill Road | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| Christian | | | Martin | | | Catherine | | | Anton | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | | | |
| Navy | | | WW I WW II | | | 219 10 1900 | | | Daughter: Katherine Trimble | | | Perry Hall, Md. | | | 9917 Pepper Hill Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> | | | | | | | | | | | | | | | | | |
| 4140 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| <u>Organic Brain Syndrome</u> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | |
| | | | P.M. | | | 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | STREET | | | CITY OR TOWN | | | COUNTY | | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 11</u> 19 <u>78</u> to <u>April 8</u> 19 <u>81</u> KATHERINE | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | | | |
| <u>D.E. Rayson</u> | | | | | | | | | | | | | | | | | |
| DEGREE | | | | | | | | | | | | | | | | | |
| 22c. DATE SIGNED | | | | | | | | | | | | | | | | | |
| 4-8-81 | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | | | | | | | | |
| Glendon Rayson | | | | | | | | | | | | | | | | | |
| 22e. ADDRESS | | | | | | | | | | | | | | | | | |
| VAMC, Perry Point, Maryland | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | | | | | |
| Entombment | | | Apr 13 1981 | | | Dulaney Valley Memorial | | | Cockeysville | | | Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| NAME | | | ADDRESS | | | APR 10 1981 | | | | | | | | | | | |
| Leonard J. Ruck, Inc. | | | Baltimore, Maryland | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | REG. NO. | |
|--|--|---|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | 81 10507 | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Ruth I. McCall | | | | | 2a DATE OF DEATH MONTH DAY YEAR
Apr. 14, 1981 | |
| 3 SEX
Female | | 4 RACE
White | | 2b HOUR
3:45p | | |
| 5 DATE OF BIRTH MONTH DAY YEAR
Jan 18, 1909 | | 6 AGE (IN YEARS LAST BIRTHDAY)
72 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Princeton N.J. | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9 BALTIMORE CITY OR COUNTY OF DEATH
Cecil MD. | | | | | 10 CITY OR TOWN OF DEATH
Elkton | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Hospital | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 12b KIND OF BUSINESS OR INDUSTRY
Home | | | | | 13a STATE
Md. | |
| 13b COUNTY
Cecil | | 13c CITY OR TOWN
North East | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Robert Jones | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Unknown | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
213-42-4422 | | 17 INFORMANT ADDRESS
Wilmer McCall 706 Hances Pt. Rd.
North East, Md. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).
4100 Auto myocard Infaction.
DUE TO, OR AS A CONSEQUENCE OF (b).
Hypertension.
DUE TO, OR AS A CONSEQUENCE OF (c).
MSVD, C.V.I. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (u) (this hospital) attended the deceased from 1/17, 1974, to 8/30, 1980, that (u) (we) lost saw the deceased alive on 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (u) (we) did (did not) view the body after death. | | | | | | |
| 22b SIGNATURE
Jui-chih Hsu, MD | | | | | 22c DATE SIGNED | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Jui-chih Hsu, M.D. | | | | | 22e ADDRESS
223W. main St. Elkton, Md. | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
4-17-81 | | 23c NAME OF CEMETERY OR CREMATORY
North East Meth. | | |
| 23d LOCATION CITY OR TOWN
North East Cecil Md. | | 23e COUNTY
Cecil | | 23f STATE
Md. | | |
| 24 FUNERAL DIRECTOR
Paul R. Coward | | | | | 25a DATE REC'D. BY REGISTRAR
APR 20 1981 | |
| 25b REGISTRAR'S SIGNATURE
H. J. McCreedy | | | | | | |

BP



Handwritten text, possibly a date or signature.

Handwritten text, possibly a date or signature.

Handwritten text, possibly a date or signature.

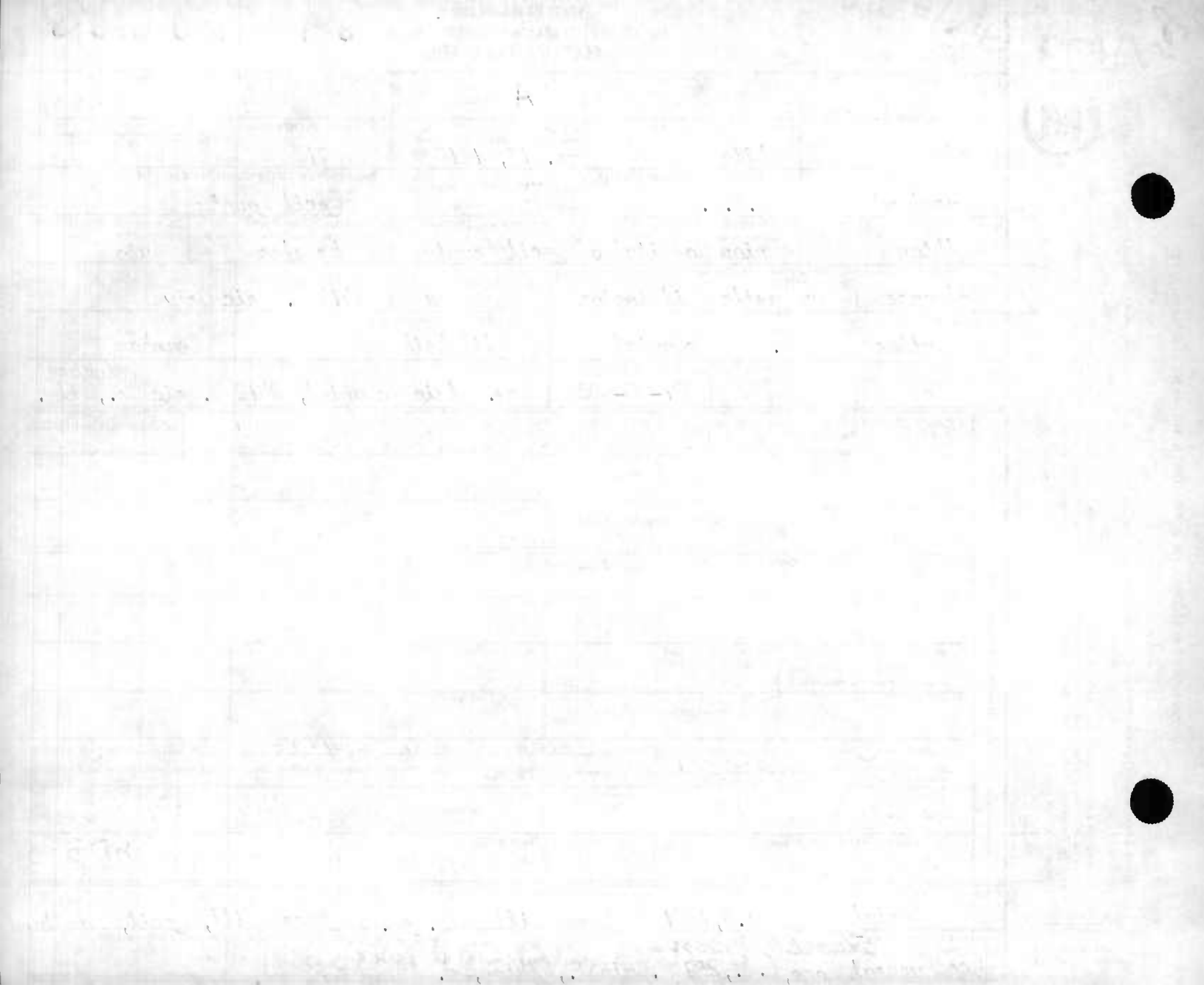
Handwritten text, possibly a date or signature.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8110508 | |
|---|--|--|--|--|---|--|--|---|-----------------------------|---|--|
| FOR
1. STATE
REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) DELIBERT W. McDANIEL | | | | | 2a. DATE OF DEATH
MONTH 4 DAY 3 YEAR 81 | | | | 2b. HOUR
11:55 PM | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH Jan. DAY 15 YEAR 1910 | | 6 AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Cecil County MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Hospital of Cecil County | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chrysler | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Delaware 13b. COUNTY New Castle 13c. CITY OR TOWN Wilmington | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
2414 W. Eric Drive | | | | |
| 14 FATHER'S NAME
FIRST Walter MIDDLE B. LAST McDaniel | | | | | 15 MOTHER'S MAIDEN NAME
FIRST Elizabeth MIDDLE Downham LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
221-07-8025 | | 17 INFORMANT
ADDRESS Delaware
Mrs. Elsie McDaniel, 2412 W. Eric Dr., Wilm. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Respiratory Cardiac Arrest
2500
DUE TO, OR AS A CONSEQUENCE OF
(b) Severe pneumonia R+Lung
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes Mellitus - | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION
29 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/24 19 81 , to 4-3-81 19 , that (I) (we) last saw the deceased alive on 4-3-81 19 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Jayantilal K. Patel | | | | DEGREE
MD - ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
4/7/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JAYANTILAL K. PATEL MD | | | | 22e. ADDRESS
123 Singlerly Ave, ELKTON MD 21921 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Apr. 8, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Cherry Hill Meth. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cherry Hill, Cecil, Maryland | | | | | |
| 24 FUNERAL DIRECTOR
NAME Edward M. Hannon ADDRESS Gee Funeral Home, P.A., 259 E. Main St., Elkton, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
APR 13 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|--|-------------------|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 1 10509 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| Bertha McEwing | | | | | 4 30 81 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 2b. HOUR | |
| Female | | White | | 12 16 83 | | 97 | | 2:00A M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. MONTH | |
| Maryland | | U.S.A. | | | | Cecil County | | 81 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. STREET ADDRESS | |
| Elkton, Md. | | Union Hospital of Cecil Co. | | Nurse | | Nursing | | 979 Frenchtown Rd., B.D. #7 | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Elkton, Md. | | Cecil | | Elkton, Md. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 979 Frenchtown Rd., B.D. #7 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Lewis | | Lena | | No | | 203-07-5220 | | Me. W. Andrew Seth, 979 Frenchtown Rd., Elkton, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | |
| 4292 | | Acute Pulmonary Edema | | Cardiac | | 4 hrs | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) Arterio Sclerotic Cardiovascular | | (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 30, 1981, to April 30, 1981, and that (I) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| | | Ernest W. Seiter M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | April 30, 1981 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. ADDRESS | | | | | |
| ERNEST W. SEITER M.D. | | Union Hospital of Cecil Co. | | Elkton, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | May 2, 1981 | | Cherry Hill Meth. Cem. | | Cherry Hill, Cecil Co., Md. | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| See Funeral Home, P.A., 259 E. Main St., Elkton, Md. | | MAY 4 1981 | | | | | | | |

BP

Building

Residence

Female

White

Union League of Coal Co.

Elkton, Md.

Elkton, Md. Coal

Elkton, Md.

Elkton, Md. Coal

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VRA15 ME (1))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 10510 | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Michael David McKay | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
4 30 19 81 | |
| 3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR April 5, 1957 6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS. 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 30 19 81 | | | | | | | | | | 2b. HOUR A.M. P.M. 5:35 A.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County | | | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH Elkton 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brakeman 12b. KIND OF BUSINESS OR INDUSTRY Conrail Railroad | | | | | | | | | | road | |
| 13a. STATE Maryland 13b. COUNTY Cecil 13c. CITY OR TOWN Perryville 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 624 Aiken Avenue | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bernard L. McKay 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beverly Neff | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) XXX No (IF YES, GIVE WAR OR DATES) ----- 16b. SOCIAL SECURITY NO. 218-70-2750 17. INFORMANT ADDRESS 624 Aiken Avenue Bernard McKay Perryville, Md. 21903 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral trauma
8150
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:30 P.M. 4 30 19 81 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver in auto/fixed object collision | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Principio Rd, Port Deposit, Cecil, Maryland | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] M.D. Assistant MEDICAL EXAMINER DATE 4/30/81 SIGNED | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn Street, Baltimore, MD. 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE May 2, 1981 23c. NAME OF CEMETERY OR CREMATORY Principio Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Perryville Cecil MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland 25a. DATE REC'D. BY REGISTRAR MAY 5 1981 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | |

1. 9. 2000

Journal of Management Education 32(1)

003-1-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8110511 | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
AKA <u>ALAN A. OSGOOD</u> | | | | 2a. DATE OF DEATH
MONTH <u>4</u> DAY <u>12</u> YEAR <u>81</u> | | | | 2b. HOUR
<u>140</u> M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH <u>Oct.</u> DAY <u>15</u> YEAR <u>1922</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>58</u> YRS | | 7. UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> | | 8. UNDER 24 HRS
HOURS <u></u> MIN <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Belgium | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Cecil MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chemical Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Delaware | | | | 13b. CITY OR TOWN
New Castle | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
32 Woodhill Drive | | | |
| 14. FATHER'S NAME
FIRST <u>Claude</u> MIDDLE <u></u> LAST <u>Osgood</u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Flora</u> MIDDLE <u></u> LAST <u>DuPree</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW 2
145-14-9939 | | 17. INFORMANT
Kenneth R. Osgood
ADDRESS Newark, Del. 19711
32 Woodhill Dr. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>
<u>4100</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u></u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>7-10</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Pneumonia, with pulmonary hypertension</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>3/31</u> 19 <u>81</u> , to <u>4/12</u> 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>4/11</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Edgar E. Folck, M.D.</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>4/13/81</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Edgar E. Folck, M.D.</u> | | | | 22e. ADDRESS
<u>Elkton, Md</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
<u>4/13/81</u> | | 23c. NAME OF CEMETERY OR CREMATORY
Cratin and Ferris | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
West Chester, Chester, Pa. | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Kellogg T. Jones</u> | | | | ADDRESS
<u>Newark, Del.</u> | | | | 25a. DATE REC'D BY REGISTRAR
<u>4/13/81</u> | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 2711 Greater Baltimore with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST
Brooks E. PLATT | | | | | MONTH DAY YEAR 2b. HOUR
APRIL 30 1981 8:05 PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR
MONTHS DAYS | |
| Male | | White | | MONTH DAY YEAR
July 12, 1900 | | 80 YRS | | IF UNDER 24 HRS
HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| PENNSYLVANIA | | U.S.A. | | | | CECIL MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| CALVERT, Md. | | CALVERT MANOR HRS. HOME, INC. | | | | Machineryman | | Mt. Ararat Farms | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | CECIL | | PORT DEPOSIT | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1487 SAINBRIDGE ROAD | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST
ERWIN PLATT | | FIRST MIDDLE LAST
INEZ PLOWMAN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 212 32 1999 | | MRS VIOA PLATT (Wife) above address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Soban pneumonia
4810 DUE TO, OR AS A CONSEQUENCE OF
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Anticoagulant cardiovascular disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-15, 19 80, to 4-30, 19 81, that (I) (we) last saw the deceased alive on 4-30, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Phil Taylor MD | | | | | | | | 5-3-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Neil Taylor MD | | Rising Sun, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| Burial | | May 4, 1981 | | Hopewell Cemetery | | Port Deposit Cecil, Md. | | | |
| 24. FUNERAL DIRECTOR FOR
Lee A. Patterson & Son, Perryville, Maryland | | | | | | | | | |

July 1, 1900

Miss

Dear Mother

x

no

Yours truly,
John D. ...

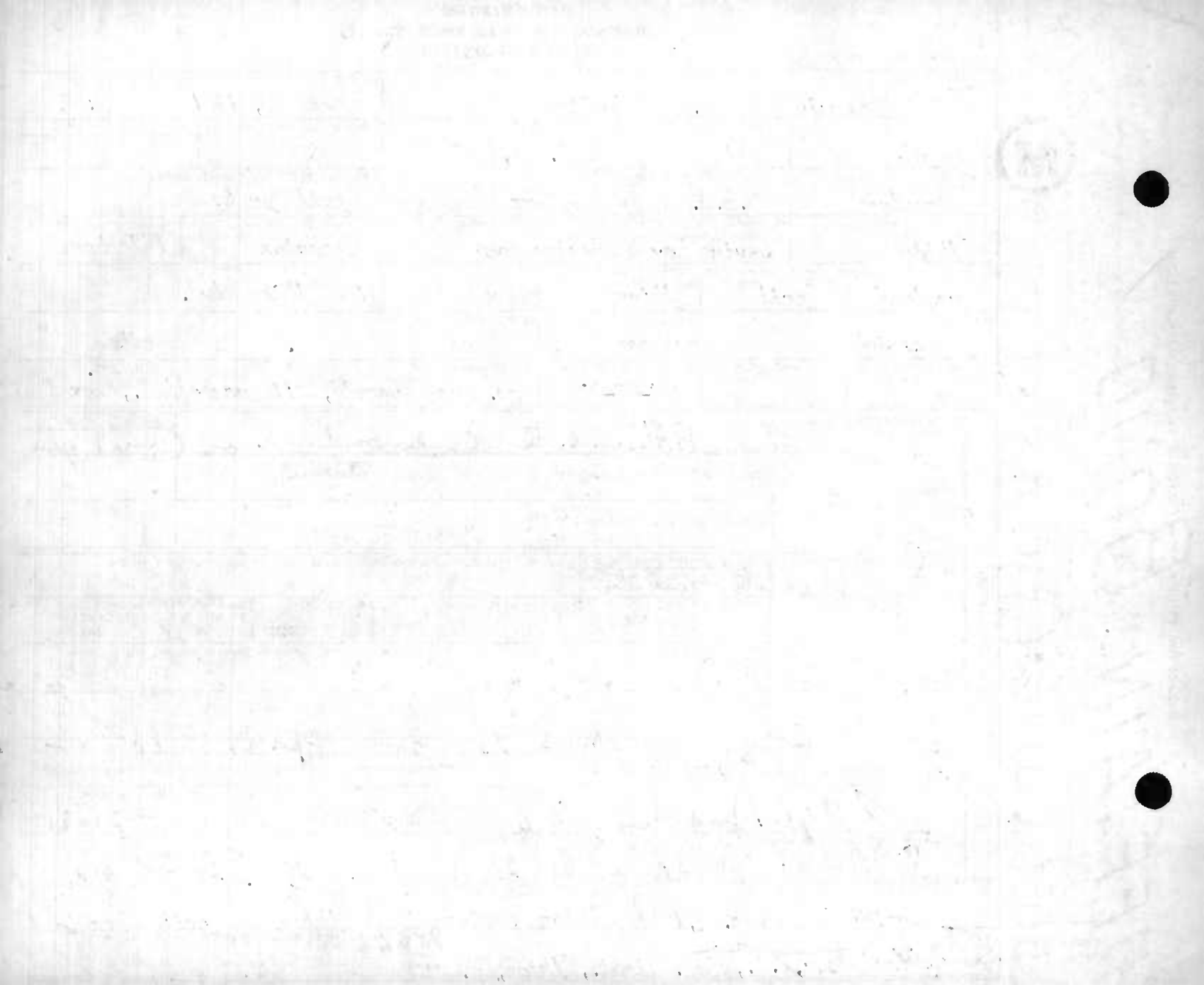
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8110513 | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Bessie V. Potter | | | | 2a. DATE OF DEATH MONTH DAY YEAR
April 20, 1981 | | | | 2b. HOUR
2:05 P.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 31, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 74 HRS
HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Cecil County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Devine Haven Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
Telephone | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Cecil | | 13c. CITY OR TOWN
Elkton | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
105 Elkton Blvd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Jeremiah Masemore | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary C. Walker | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
212-05-0320 | | 17. INFORMANT ADDRESS
Mrs. Mary Purcell, 2811 Marshall Rd., Drexel Hill Pa. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). 4049 Arteriosclerotic Cardiovascular Disease Over 1 year
DUE TO, OR AS A CONSEQUENCE OF (b). disease
DUE TO, OR AS A CONSEQUENCE OF (c).
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Diabetic mellitus | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Over 1 year | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from March 30, 1978, to April 20, 1981, that (I) (we) last saw the deceased alive on April 19, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
S. Ralph Andrews M.D. | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
4-20-81 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. RALPH ANDREWS M.D. | | | | 22e. ADDRESS
233 E Main St. Elkton, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Apr. 23, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Elkton Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Elkton Cecil Maryland | | | |
| 24. FUNERAL DIRECTOR NAME
Gee Funeral Home | | | | ADDRESS
A., 259 E. Main St., Elkton, Md. | | | | APR 22 1981 REGISTRAR'S SIGNATURE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 1 0 5 1 4 | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Arthur R Ruzat | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Apr 26 81 | | 2b. HOUR
6:15A | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb 8 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna/ | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Cecil | |
| 10. CITY OR TOWN OF DEATH
Earleville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Crystal Beach Manor | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
merchandising | | 12b. KIND OF BUSINESS OR INDUSTRY
clerical | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Cecil 13c. CITY OR TOWN Earleville | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
rural-Crystal Beach Manor | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph - Ruzat | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emilie - Buscher | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 2 | | 17. INFORMANT
ADDRESS
Mrs. Gladys E. Ruzat, Broomall, Pa. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
Arteriosclerotic Heart disease
IMMEDIATE CAUSE (a)
4140
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Probable coronary artery disease, MI in Feb 81, Rescction of anurysm | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, RECORDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the doctor) attended the deceased from Apr 12 , 19 81 , to Apr 26, 1981 , Apr , that (I) (we) lost saw the deceased alive on Apr 25 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Wallace Obenshain M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Apr 26, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wallace Obenshain, M.D. | | | | 22e. ADDRESS
Cecilton, Md. 21913 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
4/29/81 | | 23c. NAME OF CEMETERY OR CREMATORY
Cratin and Ferris Crematory, West Chester, Pa. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
Ralph E. Hicks
HICKS HOME FOR FUNERALS, ELKTON, MD. | | | | 25a. DATE REC'D. BY REGISTRAR
4 1301 | | 25b. REGISTRAR'S SIGNATURE | |

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8110515 | |
|---|--|--|---|---|---|
| 1 - FOR STATE REGISTRAR | | | CERTIFICATE OF DEATH | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | 7a DATE OF DEATH | | 7b HOUR |
| FIRST MIDDLE LAST
Arthur W. RYAN | | | MONTH DAY YEAR
4/14/81 | | 935 A M |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7c UNDER 1 YEAR |
| Male | White | MONTH DAY YEAR
June 22, 1906 | 74 YRS | | IF UNDER 24 HRS
MONTHS DAYS HOURS MINS |
| 7d BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7e CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | USA | | Cecil MD | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR |
| Elkton | Union Hospital | | Engineers Office | | Proving Ground |
| 13a STATE | 13b COUNTY | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? | 13e STREET ADDRESS | |
| Maryland | Cecil | Elkton | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 243 East Main Street | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | |
| FIRST MIDDLE LAST
W. Louis Ryan | | | FIRST MIDDLE LAST
Cora Emma White | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | |
| No | | 216-10-5361 | | Mrs. Roxie E. Ryan, Elkton, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <div> (b) <u>RESPIRATORY FAILURE, RENAL FAILURE</u>
 DUE TO, OR AS A CONSEQUENCE OF
 (c) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u>
 DUE TO, OR AS A CONSEQUENCE OF </div> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22 I certify that (I) (this hospital) attended the deceased from <u>2-24-</u> 19 <u>81</u> , to <u>4-14-</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>4-13-</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | |
| <u>Ehsanur Rahman</u> | | MD | | 4/14/81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | |
| EHSANUR RAHMAN | | 314 E. MAIN ST., NEWARK, DE 19711 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | 4/17/81 | Brookview Cemetery | | Rising Sun, Maryland | |
| 24 FUNERAL DIRECTOR | | 25a DATE RECEIVED BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| <u>Joseph E. Hicks</u> | | APR 20 1981 | | <u>Joseph E. Hicks</u> | |
| HICKS HOME FOR FUNERALS, ELKTON, MD. | | | | | |

210-10-3061 Mrs. John. Brown, Jr.
 Louis
 van
 Cecil
 Union Industrial
 303 East Main Street
 Cecil
 22. 1908
 24

210-10-3061 Mrs. John. Brown, Jr.
 Louis
 van
 Cecil
 Union Industrial
 303 East Main Street
 Cecil
 22. 1908
 24

210-10-3061 Mrs. John. Brown, Jr.
 Louis
 van
 Cecil
 Union Industrial
 303 East Main Street
 Cecil
 22. 1908
 24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8110516 | |
|---|--|--|--|--|--|---|--|---|--|---------|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Martha V Sakers | | | | 2a. DATE OF DEATH
MONTH DAY YEAR Apr 24 81 | | | | 2b. HOUR
3:22PM | | | |
| 1 SEX
female | | 4 RACE
Caucasian | | 5 DATE OF BIRTH
MONTH DAY YEAR Apr 12 99 | | 6 AGE (IN YEARS LAST BIRTHDAY)
82 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) Pg. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Cecil MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Earleville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hacks Point | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) domestic | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Cecil | | 13c. CITY OR TOWN
Earleville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Arthur Monahan | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Mary Parke | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO
215-74-4828 | | 17. INFORMANT Violet Simpers ADDRESS 306 Main St. Trainer, Pa. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Coronary occlusion | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Arteriosclerotic Heart disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) unknown | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| Paralysis of lower extremities years, Diabetes mellitus, ASHD | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from June 19 70 , to Apr 24 19 81 , that (I) (we) last saw the deceased alive on Apr 24 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Wallace Obenshain M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
25 Apr 81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wallace Obenshain, M.D. | | | | 22e. ADDRESS
Cecilton, Md. 21913 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Apr. 29, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY
Lawncrest Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Linwood Penna. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Edward M. McKown Elkton, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
APR 30 1981 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |



Cecil, . 2113

Alina, who said, . .

Paralysis of lower extremities, limbs, etc.

Arteriosclerotic heart disease

Coronary occlusion

21-1-12

11-1-12

11-1-12

11-1-12

11-1-12

11-1-12

11-1-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 10517 | |
|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
ELIZABETH WEBB SAPP | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 5, 1981 | | 2b. HOUR
A
1:30 M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 13, 1914 | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Cecil MD. | | |
| 10. CITY OR TOWN OF DEATH
Elkton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Hospital of Cecil Co; | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Del. | | 13c. CITY OR TOWN
New Castle | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
406 S. Cass St; | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George W. Webb | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie O. Spry | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No. | | 16b. SOCIAL SECURITY NO.
215-38-0001 | 17. INFORMANT
ADDRESS
Lawrence Sapp, as above. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 Acute coronary occlusion
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hours? | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Diabetes mellitus severe, Hypertension sendary to Pylonephrtis, CHF, cardiomegaly | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this physician) attended the deceased from Jan 1, 19 80, to 5 April 19 81, that (I) (we) lost saw the deceased alive on 5 April 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. | | | | | |
| 22b. SIGNATURE
Wallace Obenshain M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4-6-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wallace Obenshain, M.D. | | 22e. ADDRESS
Cecilton, Md. 21913 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
4/7/81 | 23c. NAME OF CEMETERY OR CREMATORY
Galena Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Galena Kent Md. | |
| 24. FUNERAL DIRECTOR
NAME
Edward Fellows & Son, Millington, Md. | | ADDRESS
21651 | | 25a. DATE REC'D. BY REGISTRAR
APR 15 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

[Faint, illegible handwriting]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 4 3 81 | | 11:30 aM | |
| SAMUEL SHUVALSKY | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | WHITE | | APR. 8, 1908 | | 72 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| RUSSIA | | USA | | | | CECIL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| PERRY POINT | | VA Medical Center, Perry Point, Md. | | SALESMAN | | RETAIL | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MARYLAND | | BALTO. | | BALTO. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| REV. HILLEL SHUVALSKY | | SARAH KUTCHER | | YES | | 211 07 0308 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest Cause undetermined | | 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| MRS. SYLVIA PRESTOOP | | 4275 | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 6238 ROBIN HILL RD. BALTO., MD 21207 | | DUE TO, OR AS A CONSEQUENCE OF (b) Chronic organic brain syndrome | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | DUE TO, OR AS A CONSEQUENCE OF (c) | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED | |
| | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| | | | | 22a. I certify that (this hospital) attended the deceased from 9-8, 1976, to 4-3, 1981, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | |
| | | | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| | | | | 4/3/81 | | ROY W. CHESNUT, M.D. | |
| | | | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | |
| | | | | VAMC, Perry Point, Md. | | BURIAL | |
| | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| | | | | 4/5/81 | | MOSES MONTEFIORE WOODMOOR | |
| | | | | 23d. LOCATION | | 23e. NAME OF FUNERAL DIRECTOR | |
| | | | | BALTIMORE MARYLAND | | Balto., Md. HEIDEN | |
| | | | | APR 08 1981 | | Sol-Levinson Bros, 6010 Reisterstown Rd | |

100-111111

RECEIVED

1964

TO THE DIRECTOR, FBI

FROM THE SAC, NEW YORK

RE: [illegible]

DATE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
STACY VELVIE EVANNE STACY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 14 81 | | | 2b. HOUR
6:13 PM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 19 1947 | | 6. AGE (IN YEARS LAST BIRTHDAY)
33 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Cecil County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Hospital of Cecil County | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Cecil | | 13c. CITY OR TOWN
Elkton | | 13e. STREET ADDRESS
2170 E. Old Phila. Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Chris Sullivan | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elsie Lambert | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-48-3741 | | 17. INFORMANT
ADDRESS
Mr. Lawson D. Stacy, 2170 E. Old Phila. Rd. | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Death - Angina
2776
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardio Resp Arrest
(c) Hereditary Congenital Elongated Larynx
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/14/81 19 81 to 4/14/81 19 81 , that (I) (we) lost saw the deceased alive on 4/14/81 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | |
| 22b. SIGNATURE
Joseph G. Lanzi, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4-15-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph G. Lanzi, M.D. | | | | 22e. ADDRESS
Bridge Street, Elkton, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4-17-81 | | 23c. NAME OF CEMETERY OR CREMATORY
Sullivan Family Cemetery, Bee | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME Edward McKeown ADDRESS 259 E. Main St., Elkton, Md.
DATE RECEIVED BY REGISTRAR APR 21 1981 REGISTRAR'S SIGNATURE | | | | | | | | | |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|--|---|--|---|---|-----------------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | |
| RAYMOND EARL TACKETT | | | | | APRIL 20, 1981 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | | |
| Male | | White | | JULY 21, 1936 | | 44 YRS. | | M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Kentucky | | USA | | | | Cecil | | MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Elkton | | Union Hospital | | | | Shipping- Chrysler Corp. | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | | | | Cecil | | Elkton | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Will Tackett | | | | | Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| Yes | | | | | WW 2 | | 367-34-0112 Mrs. Rosie May Tackett, Whitleyville, Tenn. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> | | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY THROMBOSIS</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIO SCLEROSIS</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-5</u> , 19 <u>81</u> , to <u>4-20</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3/27</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| <u>Rolando A. Najera, M.D.</u> | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 4-20-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| Rolando A. Najera, M.D. | | | | | 105 E. Main Street, Elkton, Md. 21921 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | | 4/23/81 | | Bilbrey Cemetery | | CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | Whitleyville, Tenn. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME <u>Donald S. Hicks</u> ADDRESS | | | | | APR 23 1981 | | | | | |
| HICKS HOME for FUNERALS, ELKTON, MD. 21921 | | | | | | | | | | |

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1978, 1979

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1981

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 4 must be retained by the hospital or attending physician.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | |
|--|--|--|------------|---|---|--|---|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | B 1 10521 | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | 2a DATE OF DEATH MONTH DAY YEAR | | | | | | |
| Rachel N. Thompson | | | | | 4/1/81 | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b HOUR | | | |
| Female | | White | | MAY 5, 1928 | | 52 YRS | | 905 P.M. | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Cecil MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Elkton | | Union Hospital | | | | Housewife | | | | | |
| 13a STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | |
| Maryland | | | Cecil | | Elkton | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 131 Hollingsworth Manor | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| Nelson J. Walstrum, Sr. | | | | | Rhoda Birney | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b SOCIAL SECURITY NO. | | | | | 17 INFORMANT ADDRESS | |
| No | | | | | | | | | | Warren E. Thompson, Elkton, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute Congestive Heart Failure | | | | | | | | | | 24 hrs | |
| 5715 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Lung Failure, Centriac & sub | | | | | | | | | | 4 yrs | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Bronchopneumonia | | | | | | | | | | 48 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/4 to 81, to 04-01, 19 81, that (I) (we) lost saw the deceased alive on 04-01 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22a SIGNATURE Victor M. Magalong, M.D. | | | | | | | | DEGREE | | 22c DATE SIGNED | |
| | | | | | | | | | | 04-02-81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | 22e ADDRESS | | | |
| VICTOR M. MAGALONG, M.D. | | | | | | | | 325 EAST MAIN ST, NEWARK, DE 19711 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | | 4/4/81 | | Cherry Hill Cemetery | | | Cherry Hill, Maryland | | |
| 24 FUNERAL DIRECTOR NAME Ralph E. Hicks | | | | | | | | ADDRESS | | 25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE | |
| HICKS HOME FOR FUNERALS, ELKTON, MD. | | | | | | | | | | APR 6 1981 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 1 1 0 5 2 2 | |
|--|---|--|--|---|---|
| 1 - | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT)
HARRY BERT WALDORF | | 2a DATE OF DEATH
April 23, 1981 | | 2b HOUR
M | |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH
Mar. 30, 1929 | | 6 AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Cecil MD. | |
| 10 CITY OR TOWN OF DEATH
Elkton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b KIND OF BUSINESS OR INDUSTRY
Pub. School |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Md. | | 13b CITY OR TOWN
Cecil | 13c INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d STREET ADDRESS
1192 Irishtown Rd. | |
| 14 FATHER'S NAME
Harry B. Waldorf | | 15. MOTHER'S MAIDEN NAME
Martha Mustard | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b SOCIAL SECURITY NO
1948-1950 | | 17 INFORMANT ADDRESS
Dolores A. Waldorf North East, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uraemia</u>
1539
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>Advanced Colon Cancer</u>
(c) <u>Due to, or as a consequence of</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Yogish A. Patel | | DEGREE
MD | | 22c. DATE SIGNED
4/24/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Yogish A. Patel | | 22e. ADDRESS
Union Hospital Elkton, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4-26-81 | | 23c. NAME OF CEMETERY OR CREMATORY
North East Meth. | |
| 23d. LOCATION CITY OR TOWN
North East | | 23e. COUNTY
Cecil | | 23f. STATE
Md. | |
| 24 FUNERAL DIRECTOR NAME
Paul R. Crouch | | 24b. ADDRESS
North East, Md. | | 25a. DATE REC'D. BY REGISTRAR
APR 27 1981 | |
| 25b. REGISTRAR'S SIGNATURE
L. J. McCready | | | | | |

Advanced Colon Cancer
L10000000

Robert A. Jones MD

10/24/01

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|---|----------------------------|--------------------|-----------|---------|----------|---------|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| Frank T WILLIAMS | | | April 29, 1981 | | | 0:25A | | | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | 7. IF UNDER 24 HRS | 8. MONTHS | 8. DAYS | 8. HOURS | 8. MIN. |
| Male | Black | Aug. 9, 1895 | 85 | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Virginia | U.S. A. | | Cecil MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Perry Point | VA Medical Center, Perry Point, Md | Postal Clerk | US Postal Service | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | | | |
| D.C. | | Washington | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4651 Deane Ave., Apts. 207 | | | | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Unknown | Unknown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMATION | ADDRESS | | | | | | |
| Yes | 087-32-5694 | V.A.M.C. Records, Perry Point, Maryland. 21902 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | | | |
| 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Heart Disease | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 5, 1981, to April 29, 1981. | | | | | | | | | |
| 22a. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED | | | | | | |
| Julian Oejo | | | 4-29-81 | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | 22a. ADDRESS | | | | | | | | |
| Julian Oejo | VA Medical Center, Perry Point, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | | | | | |
| Removal | Apr. 30, 1980 | Woodlawn Cemetery | Bronx, Bronx, New York | | | | | | |
| 24. FUNERAL DIRECTOR | 25a. DATE RECEIVED BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Lee A. Patterson, Son, Perryville, Maryland | 1981 | | | | | | | | |
| Jenkins Funeral Home, 1895 Amsterdam Ave., N.Y.C. | | | | | | | | | |

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Nov. 9, 1915

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Penry Point

VA National Cancer, Terry Point, VA

Penry Point, VA

D.C.

Washington

%

4051 New York Ave., N.W. 207

Unknown

Unknown

Nov 24

1915

087-25-5094 (M.M.) Records, Penry Point, VA

087-25-5094 (M.M.) Records, Penry Point, VA

Christine Avenue

Connecticut State College

Acetabularia (Acetabularia) Dillman

Nov 24

Nov 30, 1915

Unknown (Penry Point)

Nov 30, 1915 (Penry Point)

Lee H. Penry Point, VA